

The Modern Hospital

NOVEMBER 1957

HIGH STANDARDS ATTRACT MORE NURSING STUDENTS

Answering the charge that educators are driving small schools out — page 60

HOW TO PREPARE THE HOSPITAL TO TREAT CARDIAC ARREST

Equipping the operating room; training the staff; conducting demonstrations — page 51

PROTOTYPE STUDY: THE 25 BED PROPRIETARY HOSPITAL

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CONTROLLING COSTS IN THE HOUSEKEEPING DEPARTMENT

Determining standards of cleanliness; measuring work output; supervision — page 67



NURSE'S APARTMENT AT MONTEFIORE HOSPITAL, NEW YORK CITY (Page 57)

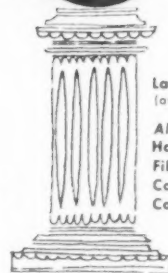


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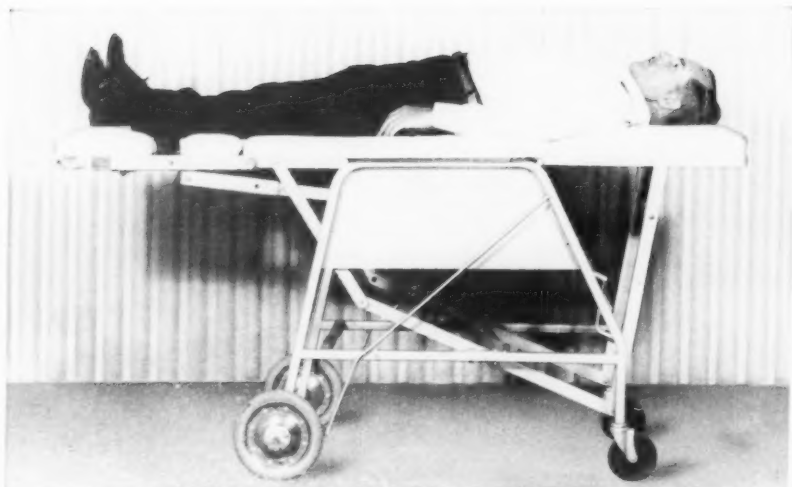
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The Modern Hospital

NOVEMBER

1957

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AMONG THE AUTHORS

Maintenance of high nursing standards and improvement of nursing education brings about an increase in applicants to nursing schools, contends **Mildred I. Lorentz, R.N.**, director of the department of nursing at Michael Reese Hospital, Chicago. On page 60, she replies to charges concerning the present status of nursing education made by Dr. Thomas Hale Jr. in the July issue of *The Modern Hospital*. Miss Lorentz



Mildred I. Lorentz, R.N.

is a graduate of the University of Cincinnati's college of nursing and health and received a master's degree from Teachers College, Columbia University. Before going to Michael Reese, she was assistant dean and professor of nursing education at Duquesne University. She served as director of the school of nursing and nursing service at Allegheny General Hospital, Pittsburgh, for eight years. Miss Lorentz is first vice president of the National League for Nursing, in addition to holding several other professional offices.

Everybody eats, so everybody thinks he knows something about food. Too often, even among hospital employees, this knowledge is based on generalizations, scanty information, or even misinformation, says **Jessie C. Obert**, head public health nutritionist for the Los Angeles County Health Department. In her article on page 100, Miss Obert points out the responsibility of the dietitian, and the hospital administrator, to check the spread of food misinformation. Staff, employees and patients must be given basic information and food and motivated to eat a good diet, she adds. Before going to the county health department in Los Angeles in 1953, Miss Obert was instructor in home management at the University of California at Los Angeles for two years. Previously, she was an assistant professor at Ohio State University for three years, and a home economist and nutritionist for various health and welfare agencies for 10 years.



Jessie C. Obert

Saving time and money in the housekeeping department can't be done casually. A methods study at Cleveland Clinic Hospital, Cleveland, determined that at least six basic factors are involved in operating a department most efficiently. On page 67, **E. J. Frederick**, **J. G. Harding**, and **Dorothy Schworm, R.N.**, explain the cost control program at Cleveland Clinic. Mr. Frederick was methods director



E. J. Frederick



J. G. Harding



Dorothy Schworm, R.N.

at the hospital when the study was made; he now is senior associate at Cresap, McCormick, and Paget, management consultants, New York. Mr. Harding, a graduate of Washington University's hospital administration course, has been the administrator since December 1952. Miss Schworm has been the executive housekeeper for the last 10 years. Prior to this she devoted her time to institutional housekeeping and organizational work in nursing. She is a past president, Cleveland chapter, National Executive Housekeepers Association.

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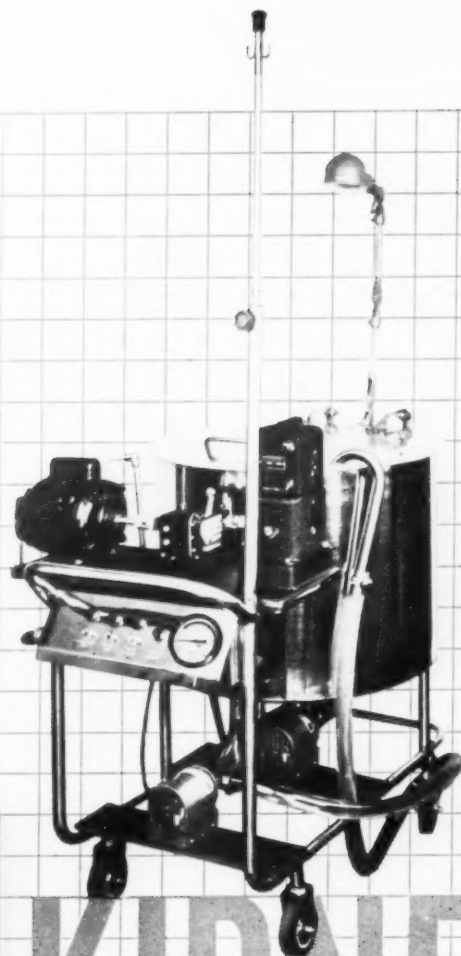
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ROVING REPORTER

Policy Quiz Hits Jackpot

At Southern Baptist Hospital, New Orleans, a way has been found to keep employes interested in personnel policies and hospital procedures. It's done with a quiz, reports the *Triangle*, the hospital's monthly publication.

The quiz is not the usual classroom examination, however, but a telephone test, with a cash prize for the employe

who can answer questions about Southern Baptist's "Policy of the Week."

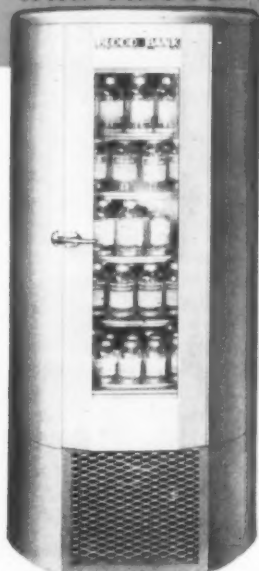
Each Monday the policy of the week is posted on the bulletin board. A quick reference to that section of the hospital's policy book gives the employe enough information to answer questions put to him by Patricia Rardin, director of inservice, or someone designated by her.

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All hospital employes, staff doctors, student nurses, and private duty nurses are eligible for the competition. Calls are made to members of each group each week, with a minimum of five employes telephoned during the week. All work shifts are included in the contest.

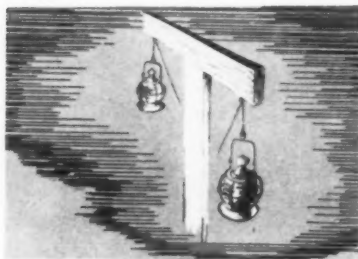
An early winner was Dr. Frank Tripp, executive secretary-treasurer of Southern Baptist's board of directors and superintendent of the hospital. He added his winnings to the jackpot and later tossed in a "mystery question" and a \$10 special prize.

Among the policies included in the contest were: employes receiving tips, admission of outpatient emergencies, general rules for maids and porters, and lost articles. If the questions for one week are not answered, the prize is added to the next week's winnings.

Booklet Shows Island Charm

"This old Nantucket expression [two lamps burning and no ship at sea] pretty well accounts for it. Why our Cottage Hospital was so late in coming, that is. The phrase means waste and extravagance ... as 'hospital' did in 1911."

The drawing and text are typical of material in a "Primer for Patients" is-



"Two lamps burning; no ship at sea."

sued by the Cottage Hospital on Nantucket Island, off the coast of Massachusetts.

In 1911 the island had no hospital, and the residents were indifferent to the need for one. The next year, however, a hospital endowment committee and two doctors bought an old home on the island. This was to be the forerunner of the present-day 37 bed Cottage Hospital that opened on May 12 of this year.

The booklet is headed, "While You're on the Ways," a Nantucket expression meaning "laid up for repairs" or "out of sorts." Following the hospital's history is information about admissions, visiting hours, services, and so on.

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Maps and line drawings of ships, New England homesteads, lighthouses, fishing equipment, and other articles typical of the area illustrate the booklet.

Hospital Puts in a Dry Day

The staff of Pontiac General Hospital, Pontiac, Mich., found out recently what it's like to be without water in a hospital. Shortly after breakfast, the water throughout the hospital was shut off for 12 hours, so that workmen could connect pipes into a newly constructed section.

Hospital personnel had prepared

well for the waterless day. Milk cartons filled with drinking water were shipped in by local dairy companies. Ten-gallon milk cans filled with water were spotted about the building.

To keep emergency tanks filled, city firemen tapped street hydrants and brought hoses through the hospital's windows. To some passing motorists, it looked as though the hospital might be fighting a fire, but there were no traffic tie-ups as a result.

Water rationing was put into effect for everything except patients' needs. The surgery schedule was rearranged

so that no operations would be performed except in an emergency. The laundry department was closed, and the pile of soiled linens became a mountain. Only a few good-natured groans were reported the next day, however.

With automatic dishwashers shut off, dishes had to be washed in the old-fashioned way—by hand. Employees carried their lunches from home or ate from paper plates.

The dry day passed smoothly, according to plan, and officials and patients praised hospital employees for the way they cooperated to meet the challenge and conduct "business as usual."—From REFLECTIONS, bulletin of Pontiac General Hospital, Pontiac, Mich.



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Good-Will Ambassadors

Many hospitals operate a baby picture program, but few take full advantage of the public appeal embodied in the photograph of a newborn infant.

The Junior Auxiliary of Altoona Hospital, Altoona, Pa., in cooperation with the hospital administration, sponsored a baby picture program for about two years, as a source of revenue and good will for the auxiliary.

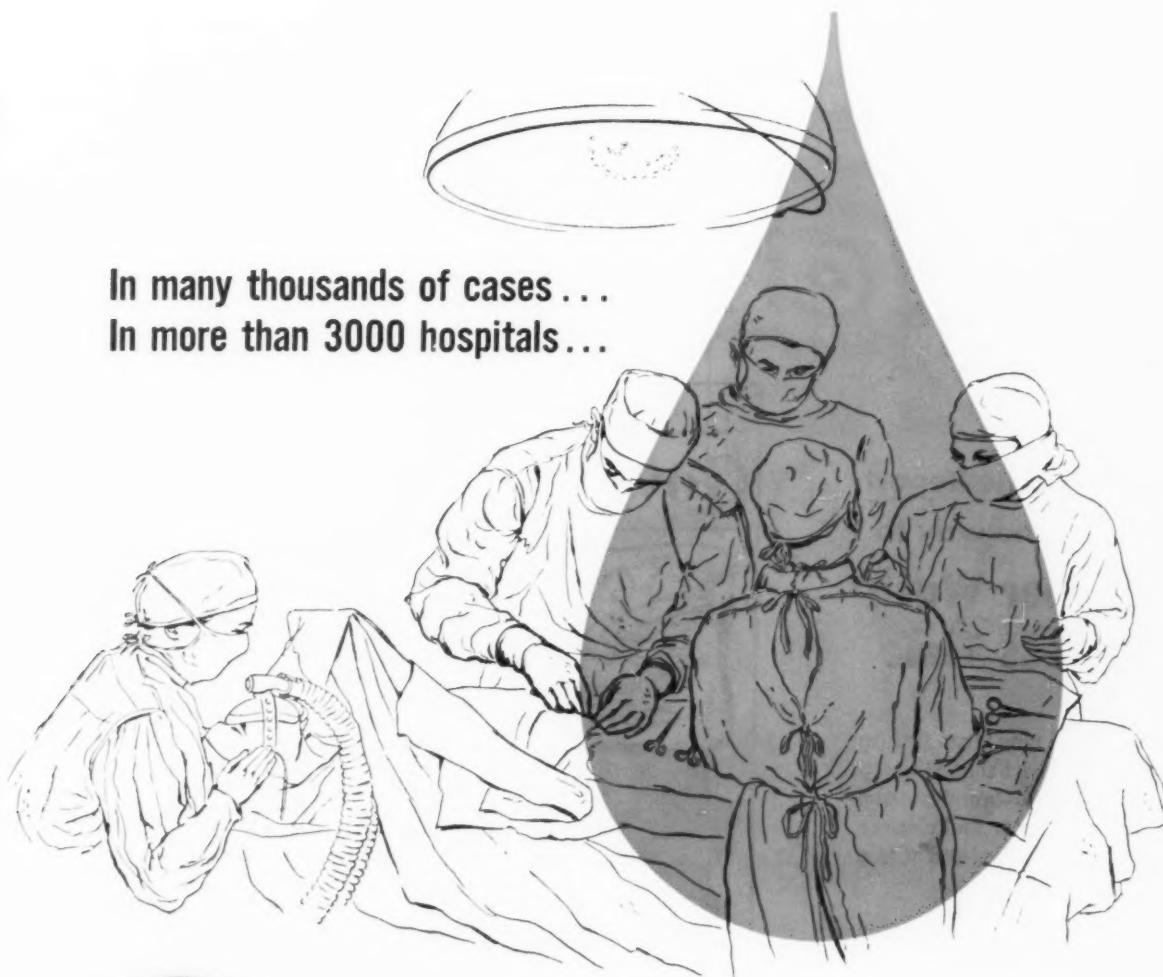
A few months ago we decided to make these pictures available to the local newspaper. The *Altoona Mirror* cooperated readily, and began publishing the pictures each Saturday.

Our photographer takes pictures of the babies each day, except Saturday and Sunday, and contact prints are forwarded to the *Mirror* on Wednesday. The pictures usually are grouped five across the three-column space, 6



Pictures are taken in this bassinet, with equipment mounted over the baby.

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to 8 inches deep. Each photograph is numbered, and the infant's last name appears in the caption below the group.

Although many hospitals may not have a photographer of their own for such a program, it should be easy to obtain the cooperation of commercial agencies to print baby pictures in the same way.

A representative from the Junior Auxiliary visits each mother in the hospital to show her finished prints

and to take orders for any proofs the family might want. At the same time, permission is requested for publication, and the mother signs a release form for the newspaper.

Since we started the new program, sales of the baby pictures have increased. We also feel that the project is one which has created much good will for the hospital and the auxiliary, and also for the newspaper.—B. F. CARR, superintendent, Altoona Hospital, Altoona, Pa.

ALTOONA, PA., SATURDAY, MARCH 30, 1937.

Governor Will Plug Sh



Recently born babies at the Altoona hospital shown according to number are: 1. Infant Ding; 2. Infant Riley; 3. Infant Shelley; 4. Infant Niemeier; 5. Infant Hamilton; 6. Infant Wolfe; 7. Infant Caputo; 8. Infant Johnson; 9. Infant Brooks; 10. Infant Ross; 11. Infant Brown; 12. Infant Leno; 13. Infant Amrhein; 14. Infant Strobel; 15. Infant Swaney; 16. Infant Tyler; 17. Infant Himes; 18. Infant Eastep; 19. Infant Mickel; 20. Infant Hoover (Amy); 21. Infant Lynam; 22. Infant Lees; 23. Infant Hoover; 24. Infant Snyder; 25. Infant Lowery; 26. Infant Beck; 27. Infant Lantz.

Readers look for this feature each Saturday in the Altoona paper. Every photograph is numbered to correspond with the name in the caption.

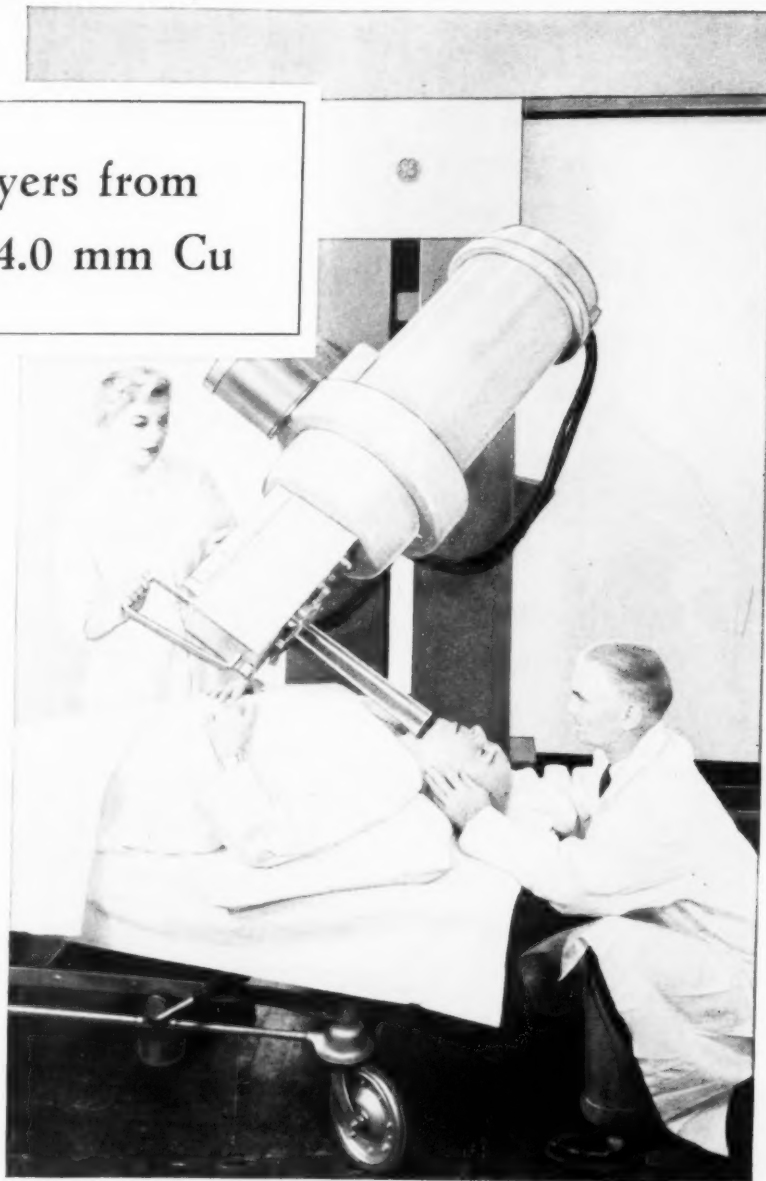
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I'M AN OPERATING ROOM SUPERVISOR

All this year I've been besieged by salesmen with something new to prove sterilization of dressings.

I tried samples of this and I tried samples of that. Some of the sterilization controls seemed to work and some didn't. I even asked our bacteriologist to check the autoclave with cultures as they were recommended to us at one of our meetings.

After all this testing, I decided that none of the methods for proving heat penetration worked as well as the system our hospital has been using for 40 years or more. The system follows the every day use of Diacks.

So again this year, just as we always have done, we're using a Diack at the center of each bundle of dressings.

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Public Relations

Education of the Community Starts With the Hospital's Own Employees

By GORDON DAVIS

IN THE burst of publicity following his appointment as Secretary of the Treasury in 1953, George M. Humphrey was widely quoted as attributing his business success to the fact that he usually does the obvious thing.

Such obvious things as getting rid of unprofitable operations and concentrating on the profitable ones, for example. Sounds not only obvious, but easy.



Gordon Davis

But there's the catch. The obvious things are often much the hardest to accomplish. In hospital public relations, one of the most obviously productive activities is employee education. Anyone who thinks that this is an easy one simply hasn't knocked his head up against it, however.

Hospital employees in general need offer no apologies for their specific job education. If they were not well trained, our standards of hospital care could not be so high. It's when you pass beyond the job to what makes the job that educational deficiencies become apparent, and in this respect hospital people are little different from most other employees.

Just as few employees of industry truly understand business, few employees of hospitals really understand hospitals. They are largely uninformed about such matters as the history and philosophy of hospitals, the hospital economy, hospital-medical relationships, interhospital relations, and the administrative organization of the hospital.

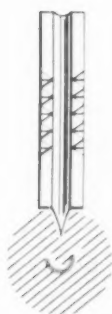
They do not know that hospitals are nonprofit, or if they do, they can't explain the term. They do not understand why the administration is boss in some matters, the medical staff in others. They have little appreciation of the reasons why a day of hospital care costs what it does. They are vague about the hospital-Blue Cross relationship and about the rôles of education and research in hospitals.

Part of the trouble is that there are no pat answers to many basic hospital questions. And yet answers are essential, for you can be certain that questions are asked of employees by patients, visitors, relatives and friends, that employees talk about their jobs, and that their collective statements constitute a potent influence on community attitudes toward the hospital.

Education of the community thus begins at home. It demands keen thinking to put hospital complexities into the everyday terms that bring understanding. It requires the determined participation of the administrator and of key members of the management team. It takes organization, continuous effort, unceasing originality. And it costs money—money for communications materials, money to pay for the man-hours devoted to teaching by management and to learning by employees.

Effective employee education, in other words, comes about only as the result of a curriculum as thoughtfully developed and implemented as any other organized course of study.

That, of course, is obvious—just as obvious as the fact that good employee education is a basic secret of hospital public relations success.



NEW B-D STERILE DISPOSABLE BLOOD LANCET

unique "gape-incision" gives you...

adequate blood flow

The new B-D LANCET produces a half-round incision that tends to pout or "gape"—avoids premature closure—clotting delayed.

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The "gape-incision" of the B-D LANCET makes "milking" of the finger tip unnecessary—just a gentle pressure.

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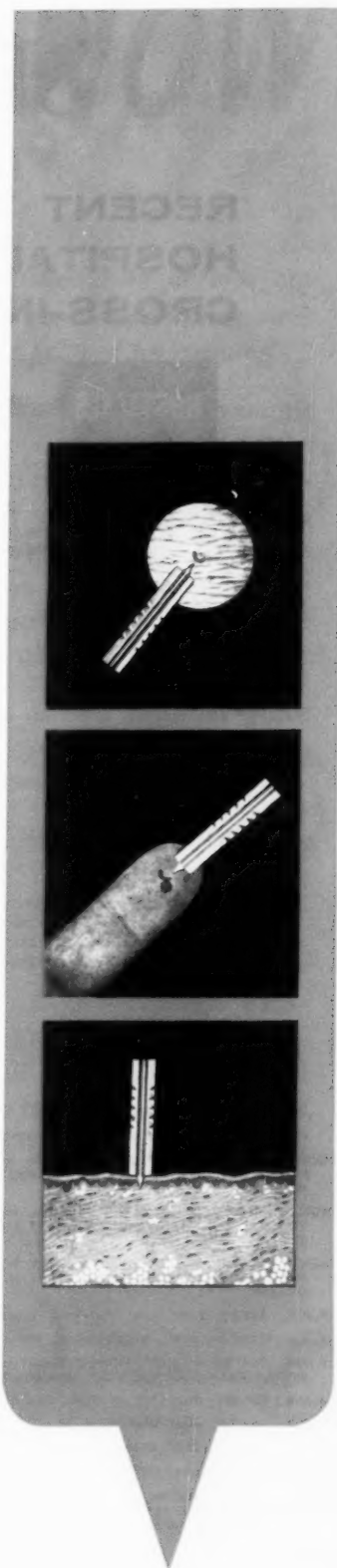
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Side flanges of the B-D LANCET automatically control depth of penetration. The angle and length of the point ensure that incision is in the region of densest capillary supply.

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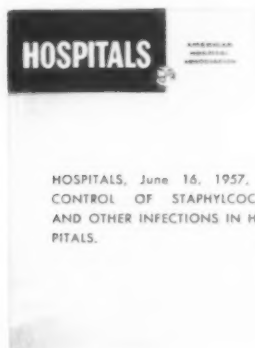
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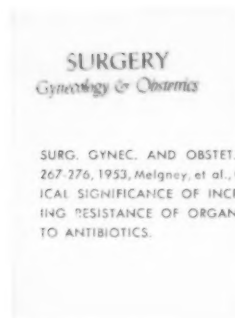
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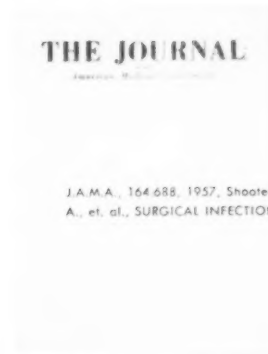
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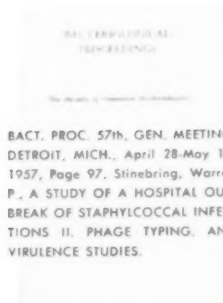
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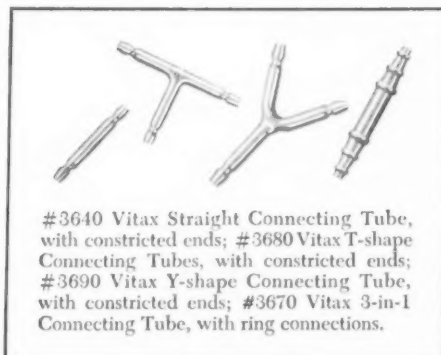
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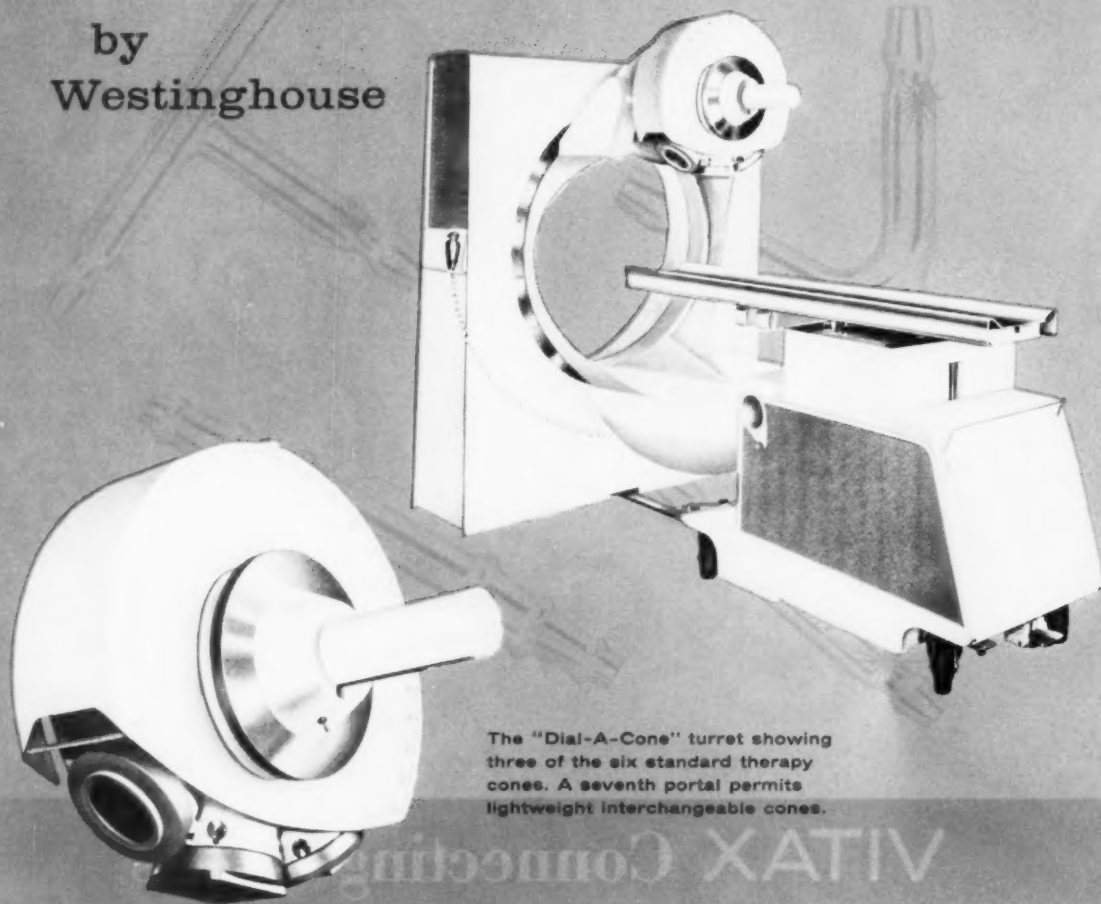
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It's the use of a newly-developed rubber compound that makes possible—for the first time—this ideal combination of comfort, sensitivity, and strength in one glove.

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Comparison tests prove that the B. F. Goodrich "Surgiderm" glove is 30 to 50 per cent softer than any regular rubber surgeons' glove, including the

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The new glove is extremely sensitive to the touch, responsive to even the slightest movement of the fingers. It is tissue thin, and uniformly thin—no heavy ends at the fingertips.

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Ask a surgeon on your staff to make a comparison test during an operation. Have him wear a "Surgiderm" glove on one hand, any other brand glove on his other hand. We think he'll be convinced that this new glove is the most comfortable he's ever worn.

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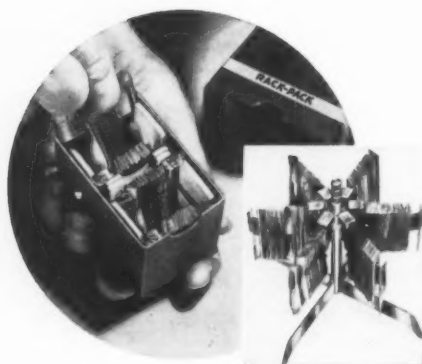
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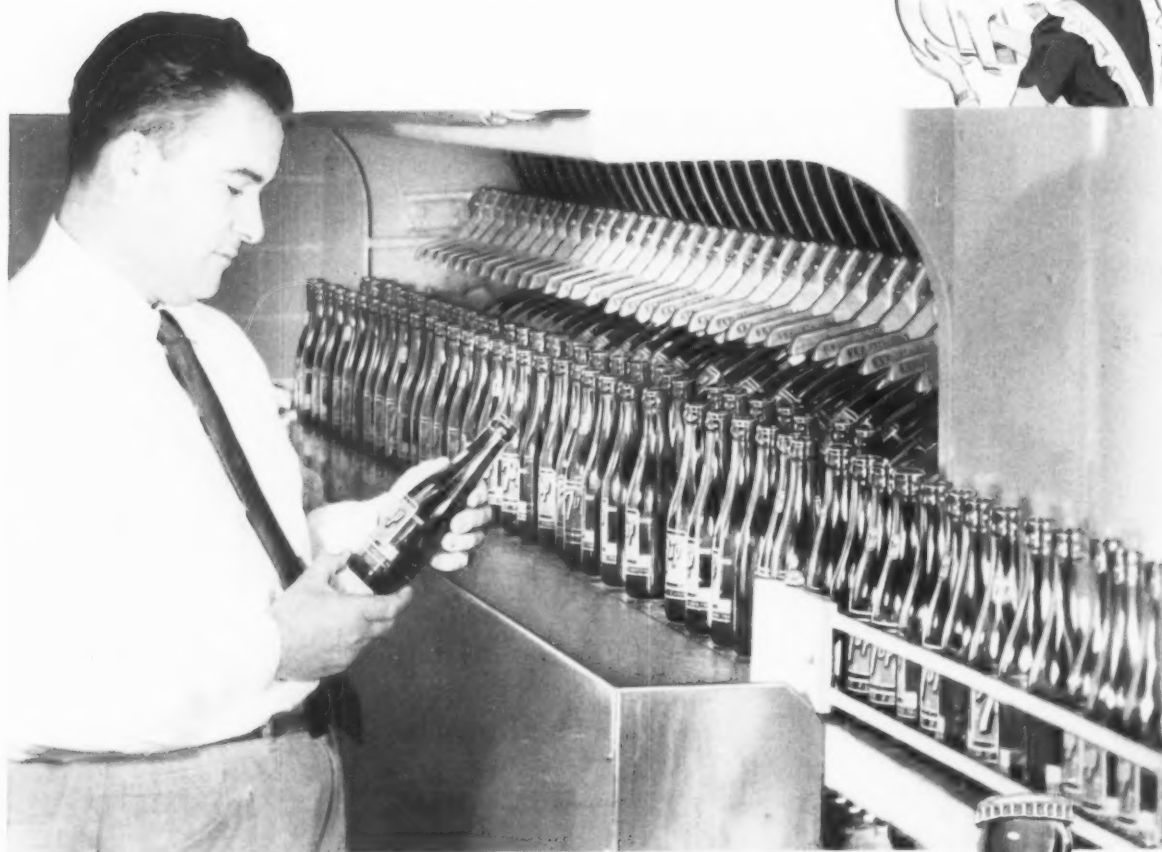
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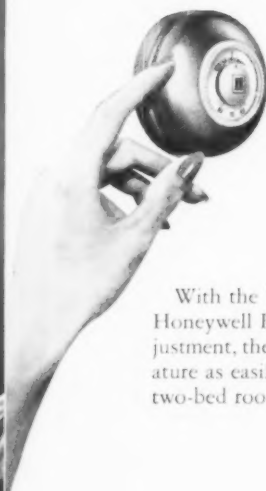
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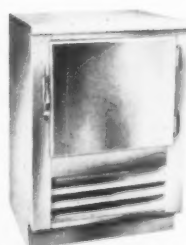
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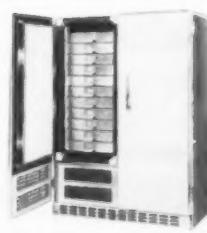
SU-24

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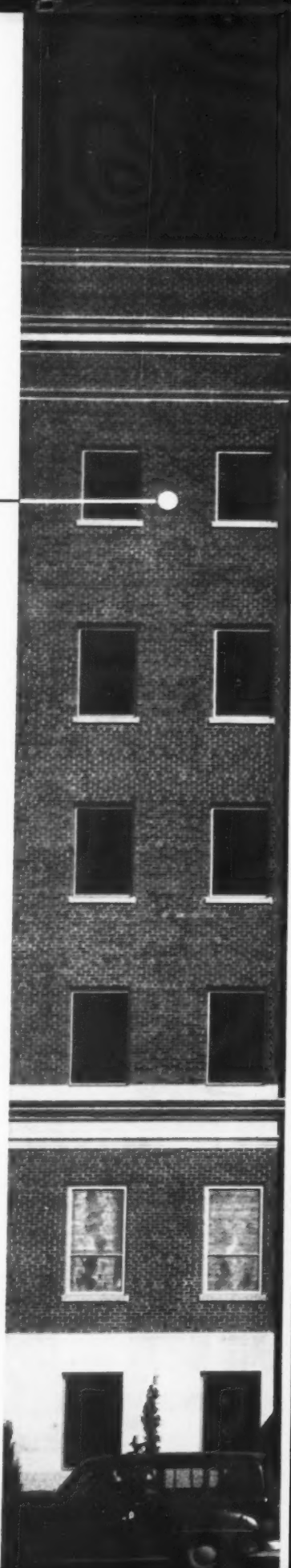
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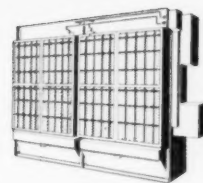
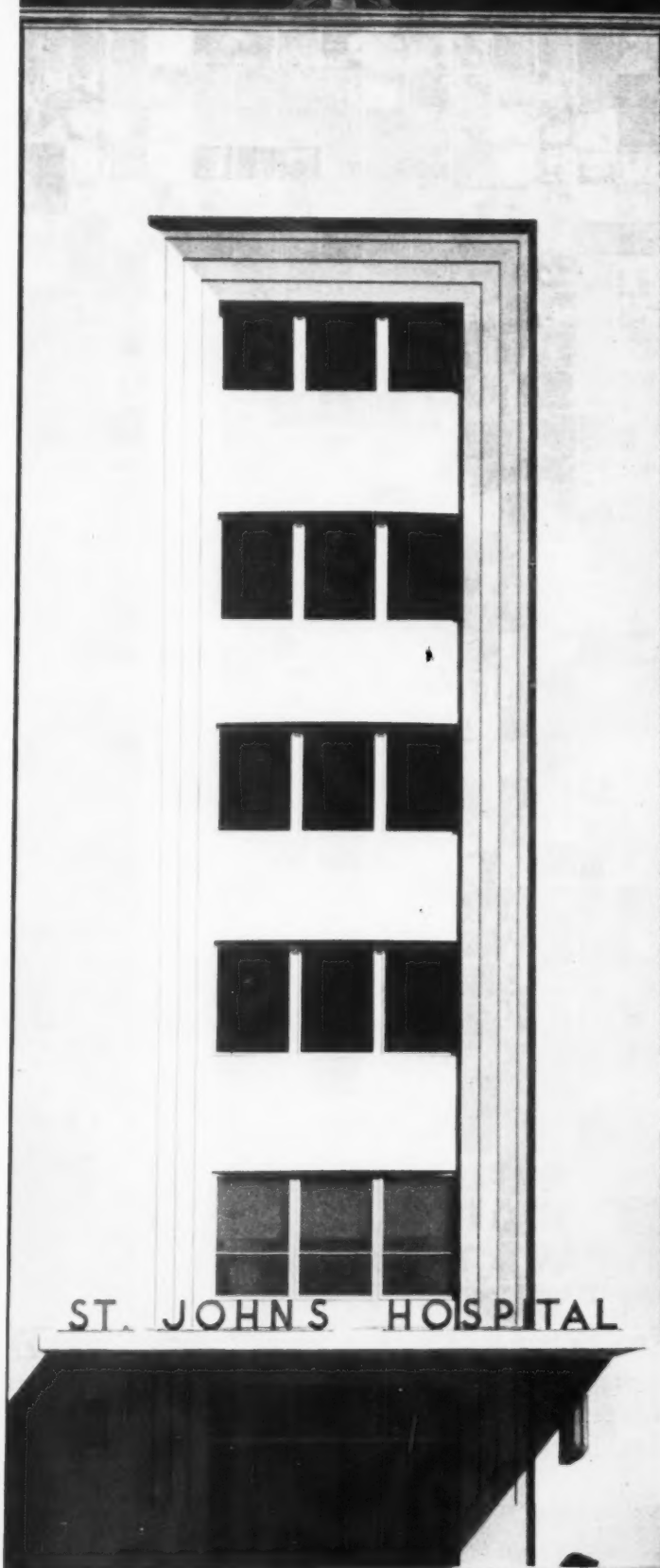


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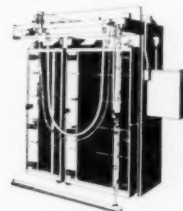
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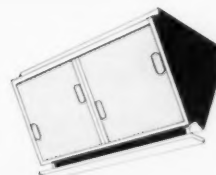
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1. Alexander, Edythe L.: Mod. Hosp., May, 1957

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Standard vs. Disposable Unit Enema: Rainier, W. G. and Lee, B., *Hospitals*, 31:50, January 1, 1957.

(1) Swinton, N.W., *Surg. Clin. No. Am.*, 35:333, 1955

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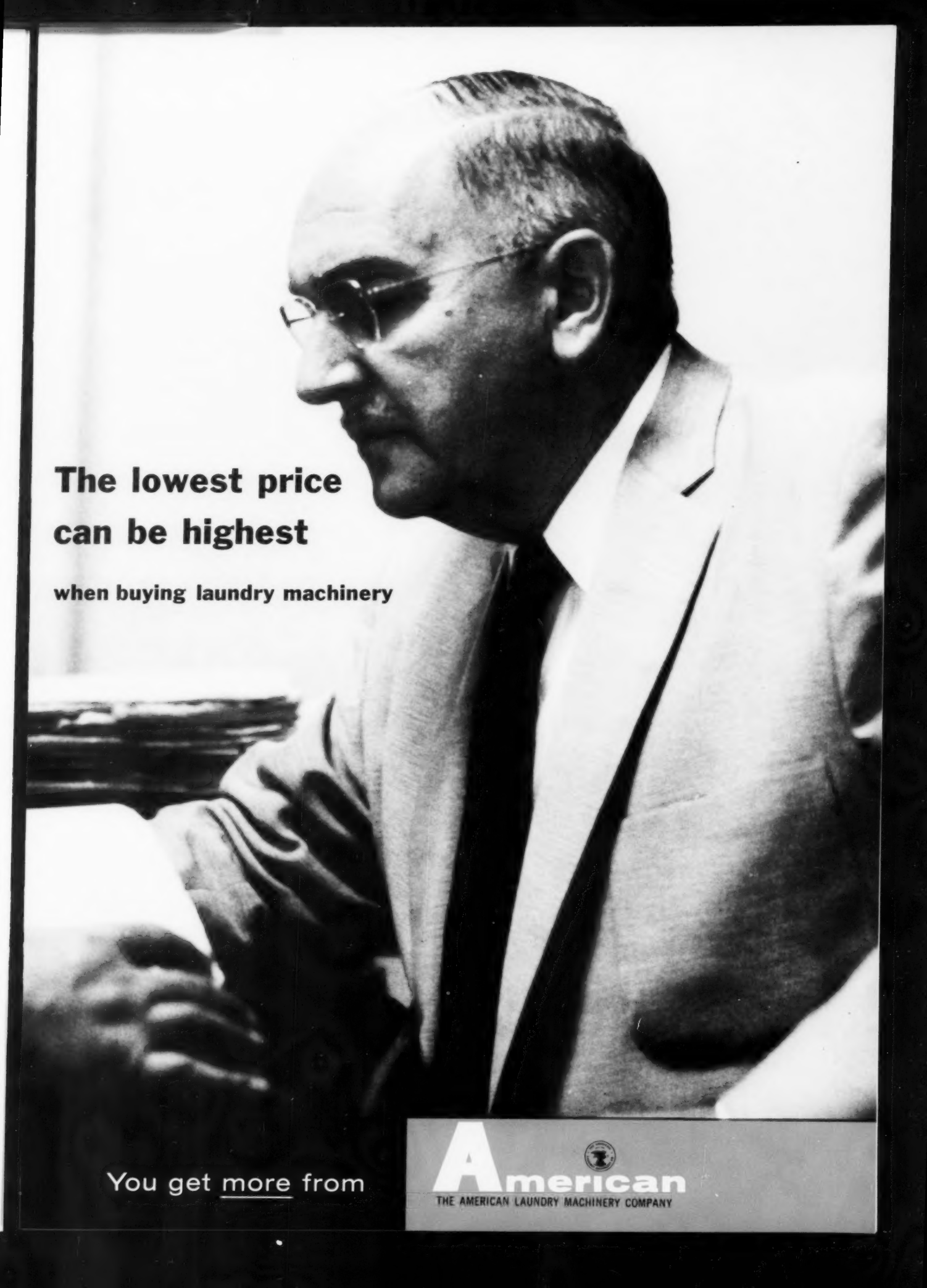


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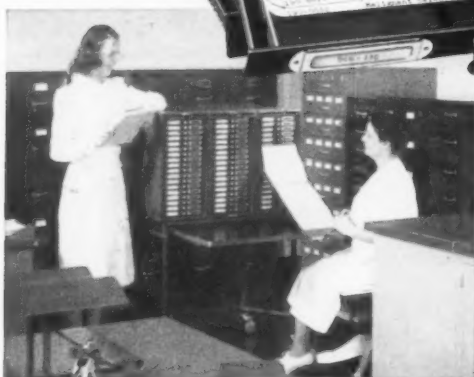
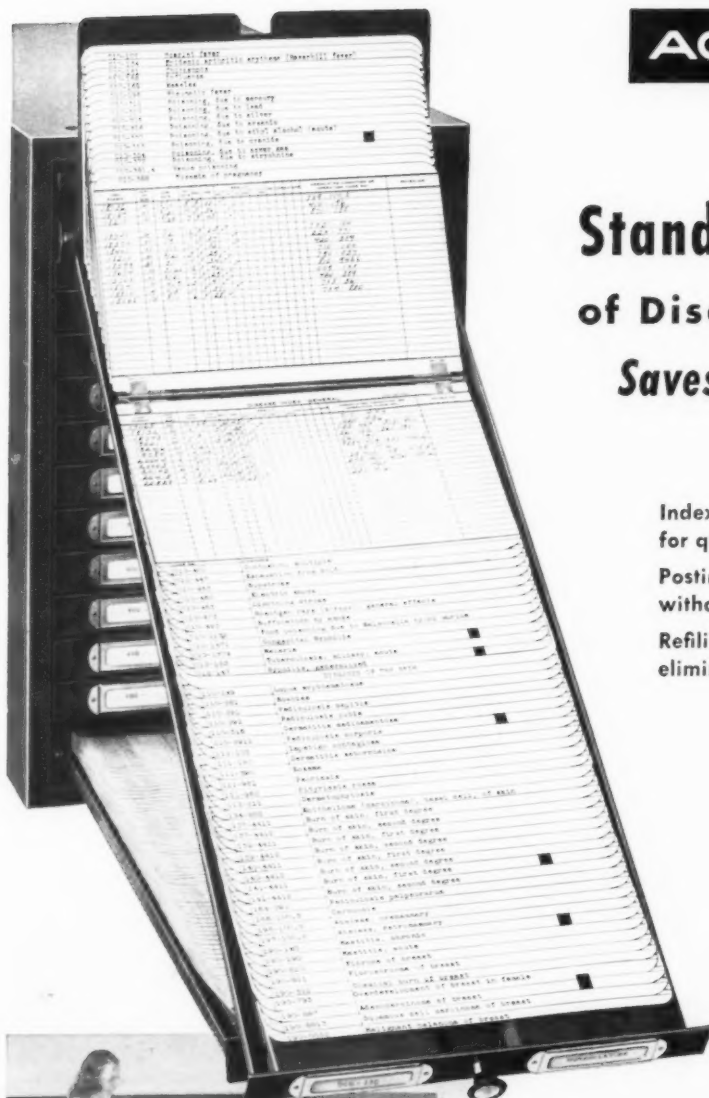
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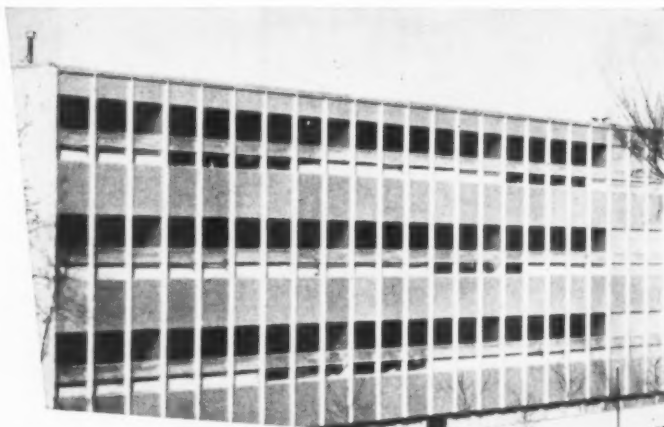
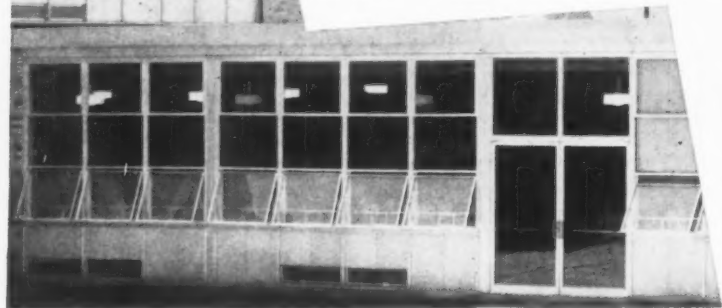
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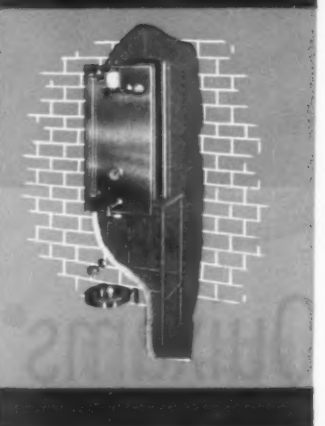
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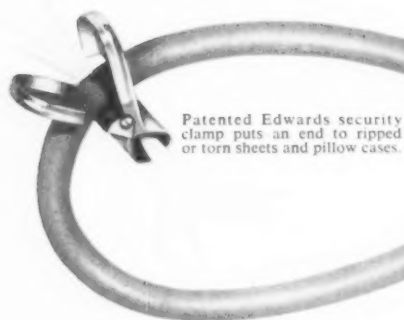
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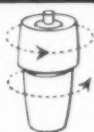
Step on it! Drop it! The molded Nylon shell withstands shock. Will withstand severest use.



Attractive grey color of button, cord, and plug never fades... cord never dries out or cracks.



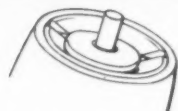
Built-in strain relief assures positive connections at all times.



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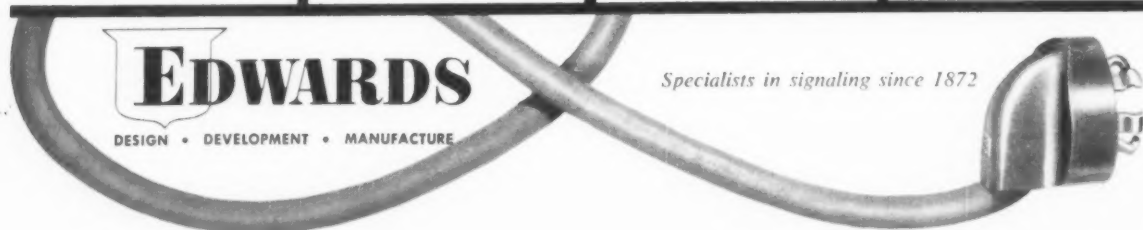
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they see it! In a bright, sparkling Libbey glass a drink looks better . . . more tempting . . . more satisfying. Libbey's wide choice of patterns gives you attractive glassware for every need . . . crested, if you want, for distinction.



taste:

they taste it! Customers taste *only* the ingredients you put into the glass—never the glass itself. Glass is inert and never imparts flavor to the beverage. Libbey's lovely crystal clear glasses help drinks taste better because they look better. Libbey tumblers and matching stemware add tasteful unity to your bar and dining service, too.



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they touch it! A cool or frosty glass is the perfect start towards drink enjoyment. Libbey glassware feels good in the customer's hand, is balanced just right. And Libbey offers the right glass for every drink.



smell:

they smell it! Customers get only the delightful bouquet of the beverage . . . never any foreign odor from inert glass. Libbey glassware is easy to keep sparkling clean without danger of chipped rims because of the famous Libbey "Safedge" Glassware rim.



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Columbian Tumbler, Iced Tea Glass, HT-1806, 12-oz. This handsome pattern is available in 9 sizes.

Nothing takes the place of a Libbey glass in beverage service


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Libbey Safedge Glassware is the ideal service for all beverages . . . combining sense-appeal with amazing durability and economy. In restaurants throughout the country, Libbey Heat-Treated glasses have been tested and proved to give the highest average number of servings per tumbler . . . which means a per serving cost to you measured in fractions of a cent per 1000 servings.

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terns and sizes . . . crested with your monogram or insignie for distinctive identification . . . extremely durable glassware for economical operation, with every glass backed by Libbey's famous guarantee: "A new glass if the rim of a Libbey 'Safedge' glass ever chips."

That's why it makes good sense to serve *all* beverages in Libbey Safedge Glassware. Find out how Libbey can mean savings and profits in your operation. Call your Libbey Supply Dealer today, or write to Libbey Glass, Division of Owens-Illinois, Toledo 1, Ohio.

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Now... "COLD" STERILIZATION WITH THE AMERICAN *Cry-O-THERM*

Climaxing more than eight years of intensive research and development by American Sterilizer, the *Cry-O-Therm* establishes wholly new standards for cold (gaseous) sterilization of instruments and wrapped or pre-packaged surgical and laboratory supplies. Simple to install, easy to operate, fast, safe and fully automatic, the *Cry-O-Therm* provides the first completely practical technique for hospital sterilization of heat- or moisture-sensitive items.

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new gaseous sterilizing agent known as *Cry-OXCIDE* has been developed by Amsco. In convenient, disposable, aerosol containers, *Cry-OXCIDE* combines ethylene oxide and inert gases in a low-pressure, non-flammable, non-explosive mixture.



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Square 16" x 16" x 30" chamber has ample capacity for largest endoscopic instrument. Fully automatic with full-load cycles as fast as two hours.

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NO OTHER INCUBATOR PROVIDES SO MANY OUTSTANDING FEATURES AT SUCH REASONABLE COST



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- 3) **Regulates oxygen concentration.** So vitally important in preventing retrolental fibroplasia.
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Cobalt 60 Unit above is one of the many features in the completely equipped Radiology department. It is a high energy source, for treatment of cancer and other malignancies.



In the Board Room, left to right, Dr. Paul L'Heureux, Medical Director, Sister Superior G. Jarbeau, Administrator and her Assistant Sr. A. Trottier, Mr. G. L. Pickering, Comptroller. Below on opposite page is Chief Engineer Louis Verscheure at air conditioning control panel.



The MODERN HOSPITAL

POWERS Pneumatic Temperature Control for Heating



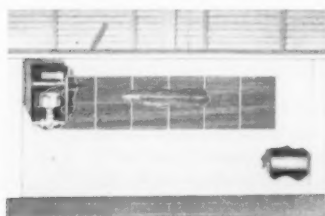
NOW, it's Canada's First Completely Air Conditioned Hospital with



Powers Temperature and Humidity Control helps Nurses to work more effectively and care for more patients. Surgeons operate with less fatigue and strain. Patients recover sooner and require less service.

Powers Pneumatic Thermostats maintain set temperatures constantly. They need no daily checking or readjusting.

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(C49)

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Central Supply Units furnish properly conditioned primary air and heated or chilled water to over 600 unit air conditioners in the

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Building: Santa Rosa Hospital, San Antonio, Texas
Architect: Phelps, Dewees & Simmons
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SMALL HOSPITAL QUESTIONS

Keep Fire Doors Closed

Question: We are in an old building with a central stairwell, now enclosed in accordance with fire safety regulations. While there are fire doors on each of three floors, we find that these are sometimes left open, or even propped open, and, since our building now has sprinkler protection, added not long ago at considerable expense, we wonder if the effort to keep fire doors closed must now be continued. Should we ask our local fire safety authorities for advice on this point?—M.A., Calif.

ANSWER: Yes, and they will tell you to keep the fire doors closed at all times—at whatever cost of educational effort among employees, supervisory checkups, and even disciplinary measures. Fires in older buildings, especially those occupied for nursing home purposes, have repeatedly demonstrated the danger of open stairwells, which become literal "chimneys" for the spread of fire when left open. Moreover, recent studies of the spread of infection in hospital buildings have shown that open stairwells may carry air-borne bacteria quickly from central, first floor areas accessible to the public to nursing floors where susceptible medical, surgical and obstetrical patients are located.

Reducing Radiation Hazards

Question: We have been reading and hearing more and more about the radiation hazard resulting from operation of an ordinary medical x-ray department and wish to make certain we are doing all that can be done to keep the hazard at a minimum. Are there new technics to be used in these departments that will reduce the hazard?—B.L.K., Ohio.

ANSWER: The United Nations' scientific committee on the effects of atomic radiation has listed the following areas of effort for reducing exposure:

1. Improvements in design or shielding of equipment.
2. Training personnel using radiographic and fluoroscopic equipment.
3. Local protection of the pelvic area, particularly during abdominal or pelvic x-ray examinations.
4. Use of radiographs rather than fluoroscopy whenever adequate information can be obtained by this means.
5. Systematic improvement of administrative procedures to obviate unnecessary repetitions of examinations of the same patients.

Manufacturers of x-ray equipment, radiologists and their professional societies are prepared to give specific advice looking toward the achievement of desired goals in all these areas. With adequately trained personnel and modern equipment, authorities believe exposure in hospital x-ray departments can be held to a fraction of the radiation levels designated as permissible by the National Committee on Radiation Protection. The American Medical Association has recommended that hospitals using radium or artificially produced radioisotopes should have a medical staff committee including a radiologist, surgeon, internist, gynecologist, urologist and pathologist establishing policies for the use of these materials; every hospital should have a safety program for the x-ray department, headed by the radiologist.

Let Fund Gifts Be Voluntary

Question: When our Community Fund campaign, of which several charitable agencies in the community—including the hospital, to a small extent—are beneficiaries, was initiated this year, employees of the hospital were urged to contribute as they have been doing in the past. However, contributions were slow in coming in from our employees, and one of our trustees who insisted the hospital should be a "pace setter" in contributions to the Community Fund wanted to make it mandatory for employees of the hospital to contribute. There was a division of opinion about this, and it was not done this year, but we feel sure the question will be raised again in connection with later drives and would like to know if this is a widespread practice among hospitals.—B.E., Ohio.

ANSWER: No. Generally speaking, hospital employees should contribute to Community Fund drives on the same

basis that other citizens do—as citizens, and not as members of a special group, and in accordance with their means and dispositions. As an employer, the hospital has the same obligation that other employers have to make certain employees understand the significance of the Community Fund concept, and the needs that are met out of donations to the fund. Pressure on employees to contribute, or compulsory contributions, are contrary to the philanthropic spirit of the Community Fund and would seem especially unsuitable in the case of the hospital, many of whose employees must still meet family obligations out of pay checks that are smaller than those prevailing in industry.

Fire Drills for Patients

Question: With all the emphasis now being given hospital fire safety, a question has come up on our staff as to whether we should conduct fire drills involving patients—at least those able to be moved. What is the standard practice among hospitals?—K.L.R., Ill.

ANSWER: The latest code of the National Fire Protection Association on this point reads as follows:

"Fire exit drills in hospitals shall include the transmission of a fire alarm signal and stimulation of emergency fire conditions except that the movement of infirm or bedridden patients to safe areas or to the exterior of the building is not required. Drills shall be conducted at irregular intervals, during day and night, to familiarize hospital personnel (nurses, interns, maintenance engineers, and administrative staff) with signals and emergency action required under varied conditions. At least 12 drills shall be held every year.

"Many hospitals conduct fire exit drills without disturbing patients by advance planning in the choice of location of the simulated emergency and closing doors to patients' rooms or wards in the vicinity prior to the initiation of the drill.

"Convalescent patients should be removed from involved zones lest their curiosity or anxiety hamper fire brigade activity, or cause themselves injury. All sections should be assured of a necessary complement of doctors, nurses, attendants and other employees in reserve, in readiness to assist in the transfer of bed patients to less exposed areas or sections."

Conducted by Jewell W. Thrasher,
R.N., Frazier-Ellis Hospital, Dothan,
Ala.; A. A. Aita, San Antonio
Community Hospital, Upland,
Calif., Pearl Fisher, Thayer Hos-
pital, Waterville, Maine, and
others.

PATIENTS ACCOUNTS RECEIVABLE DAILY REPORT

DEPARTMENT	DATE	AMOUNT	DATE	AMOUNT	DATE	AMOUNT
General	4-1-52	100.00	4-1-52	100.00	4-1-52	100.00
General	4-2-52	100.00	4-2-52	100.00	4-2-52	100.00
General	4-3-52	100.00	4-3-52	100.00	4-3-52	100.00
General	4-4-52	100.00	4-4-52	100.00	4-4-52	100.00
General	4-5-52	100.00	4-5-52	100.00	4-5-52	100.00
General	4-6-52	100.00	4-6-52	100.00	4-6-52	100.00
General	4-7-52	100.00	4-7-52	100.00	4-7-52	100.00
General	4-8-52	100.00	4-8-52	100.00	4-8-52	100.00
General	4-9-52	100.00	4-9-52	100.00	4-9-52	100.00
General	4-10-52	100.00	4-10-52	100.00	4-10-52	100.00
General	4-11-52	100.00	4-11-52	100.00	4-11-52	100.00
General	4-12-52	100.00	4-12-52	100.00	4-12-52	100.00
General	4-13-52	100.00	4-13-52	100.00	4-13-52	100.00
General	4-14-52	100.00	4-14-52	100.00	4-14-52	100.00
General	4-15-52	100.00	4-15-52	100.00	4-15-52	100.00
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General	4-29-52	100.00	4-29-52	100.00	4-29-52	100.00
General	4-30-52	100.00	4-30-52	100.00	4-30-52	100.00
General	4-31-52	100.00	4-31-52	100.00	4-31-52	100.00
General	4-32-52	100.00	4-32-52	100.00	4-32-52	100.00
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General	4-37-52	100.00	4-37-52	100.00	4-37-52	100.00
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General	4-39-52	100.00	4-39-52	100.00	4-39-52	100.00
General	4-40-52	100.00	4-40-52	100.00	4-40-52	100.00
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General	4-42-52	100.00	4-42-52	100.00	4-42-52	100.00
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General	4-47-52	100.00	4-47-52	100.00	4-47-52	100.00
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General	4-67-52	100.00	4-67-52	100.00	4-67-52	100.00
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General	4-70-52	100.00	4-70-52	100.00	4-70-52	100.00
General	4-71-52	100.00	4-71-52	100.00	4-71-52	100.00
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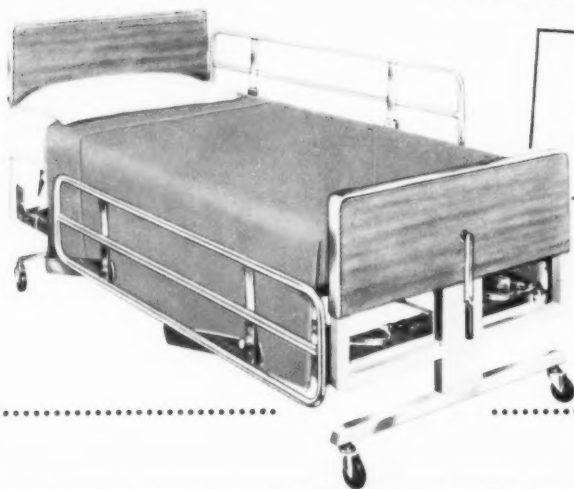
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in 30 specially devised giant printing presses, each resting on its own caissons and all totally independent of those on which the building rests. To assure the highest degree of color printing accuracy, each press unit is equipped with precision jacks capable of minute adjustments for leveling. The newsprint is delivered from a riverside dock and from rail tracks into the plant. Newspaper delivery trucks are loaded and dispatched from an enclosed concourse. In this building, where only the best would suffice, plumbing plans specified the installation of SLOAN Flush VALVES.

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wire from **W**ashington

FREE HOSPITALIZATION AT 65

Although Congress is in adjournment until January 7, there is intensive behind-the-scenes activity on one issue in the hospital field—the proposal to give free hospitalization under social security to men 65 and over and women 62 and over.

Unless the Russian-American scientific rivalry overshadows the entire legislative picture, this question of free hospital beds for the old people, which has been before Congress for more than six years, will head for a definite showdown next year.

This is the way the struggle is developing:

American Medical Association, a leader in defeating the plan when it was offered in 1951, hasn't officially announced its position on the revised proposal. But there is little question how the A.M.A. will stand or what it will do; it will continue to oppose the idea, and will fight it with all its strength, with or without allies.

A special committee appointed by the A.M.A. board of trustees currently is gathering information on the legislation now before Congress and possible alternatives. This committee won't make policy, but will make recommendations. It is scarcely conceivable that the basic factors will have changed sufficiently to cause the committee to suggest the association shift its position and support the bill.

The American Hospital Association, which avoided taking a position on the bill in 1951, still is undecided. At its fall convention A.H.A. deferred taking any action on the issue, although all the major facts were on hand. But the A.H.A.'s position is significantly different from that of the A.M.A. Until the last minute there will continue the possibility that A.H.A. will endorse the bill or decide not to oppose it.

Kenneth Williamson, A.H.A. associate director and head of its Washington Service Bureau, very frankly states:

"Federal subsidy for health care plans for older persons will occupy more congressional attention in the next session than in any previous year. . . .

"Financing health care of the aged is nothing new with the A.H.A. Since 1955 A.H.A. has recognized the national importance of this problem and has had special task forces carrying out intensified research on health care plans for older persons.

"The association's house of delegates has already approved principles guiding the development of federal legislation to meet the health needs of the aged. Reevaluation of the association's position on this issue is now being carried out by a special committee.

"All of these proposals will be under the closest scrutiny next year and the association will testify before congressional committees on one of the most important health problems of our times."

Should A.H.A. decide to back the hospitalization-of-the-aged legislation, or sit out next year's fight, Blue Cross can be expected to follow its lead, and Blue Shield may do the same thing.

(For an evaluation of factors affecting A.H.A.'s decision, see article on this page in the August issue.)

There never has been any question about how top labor leaders stand on this free hospitalization proposal. They have been all for it from the start. The plan was endorsed in general at last year's A.F.L.-C.I.O. convention, and the top officials have since given public support to a specific bill (H.R. 9467) introduced by Rep. Aime J. Forand (D.-R.I.).

There is one uncertainty about labor's position. Until time comes for the showdown next year, there is no way of telling whether this is merely a favorite of top labor leaders, or has been accepted as a labor crusade by the rank and file. To the general public, labor does not present too pretty a picture just now, but if the laboring people really want this bill and drive for it next year they would be hard to stop.

The political situation, too, has some uncertainties, but there's no uncertainty about the fact that this legislation now has far more support in both parties than it had when first proposed by President Truman and Oscar Ewing.

For the present the only bloc openly supporting the bill is the group of ultra-liberal Democrats, with a sprinkling of Republicans. However, Speaker Rayburn is understood to have cleared the track for action next year, and Chairman Jere Cooper (D.-Ky.) of the House ways and means committee will do nothing to stop the bill.

Middle-road Republicans, who might be expected to oppose the free hospitalization bill at any other time, may lose some of their conservatism next year. It is election year for all members of the House, and if the Eisenhower Administration is on the defensive on other larger issues these moderate Republicans might have to save their own political hides by voting for something they think a lot of the people want.

Finally, the position of the White House: Last year Secretary Folsom said he thought the free hospitalization plan was too close to socialized medicine, and besides that the social security program should be given some time to adjust itself to the major changes made last year.

But Administration experts are looking at the proposal again from all angles, and they might easily decide the political angle is the most appealing.

RADIO FREQUENCIES FOR HOSPITALS

Given unofficial encouragement, officials of the American Hospital Association are hopeful that the Federal Communications Commission will grant their request and set

aside three radio frequencies for the exclusive use of hospitals.

F.C.C., which received a similar request from the American Medical Association on behalf of doctors, is studying the applications, but there is no suggestion that a decision will be made in the near future. Presumably, objections will come from radio stations and other present users of channels and from telephone interests.

A.H.A.'s request emphasized the value of the channels in time of disaster, stating: "Experience has demonstrated that the successful professional and administrative operation of hospitals under disaster conditions requires an effective communications system between hospitals, between hospitals and mobile units, and between hospitals and other agencies. . . . Only radio affords assurance of such an effective communications system—telephone communication simply has not worked satisfactorily."

Explaining the value of the channels under normal conditions, A.H.A. said:

"Approximately 300 mobile units can be accommodated effectively on one frequency in a given area. If each hospital licensee had one base station and as few as 10 mobile units, one frequency could accommodate approximately 30 hospitals in a given area.

"Many standard metropolitan areas in the United States have more than 15 hospitals, and hence, would require at least two frequencies. Moreover, each standard metropolitan area having a 1950 population of one million or more has more than 30 hospitals and hence requires a third frequency."

Doctors and hospitals now must compete with such other channel users as taxicabs and radio-dispatched service trucks. Because such channels often are crowded and monopolized by various systems for pooling messages, they generally are found unsatisfactory.

MEDICAL CARE PRICE TRENDS

A special study of medical care price trends between 1936 and 1956, published in the labor department's monthly *Labor Review*, offers these findings:

In the 20 years the increase in total medical care costs was less than the increase in prices for food, personal care, and clothing.

Since 1950 there has been a noticeable decrease in the proportion of family income spent on medical care as income rises.

In the 20 years hospital room rates have gone up 264.8 per cent, general practitioners' fees, 72.8 per cent, and surgeons' fees, 59.5 per cent.

The study gives several explanations for the relatively sharp increase in hospital costs: Hospitals have had to contend with higher overhead costs and higher current operating costs, changes in medical technology have meant shorter average stays and higher per day rates because more services are performed the first few days, ancillary services (x-rays and laboratory tests) have been increasing in importance and now account for a larger share of patient charges, extensive hospital construction and new equipment purchases have to be financed in part through patient charges.

SALARY STATISTICS

Another *Labor Review* article rounds up a volume of specific and miscellaneous information on salaries and supplementary benefits in private hospitals.

American hospitals today employ about 1,300,000 people, a higher total than the steel or auto industries or interstate railroads.

General duty nurses' salaries vary from \$56.50 per week in Philadelphia to \$72 in Chicago and San Francisco.

Nursing directors' salaries range from an average of \$95.50 per week in Baltimore to \$120.50 in Minneapolis-St. Paul; in a majority of cities the average was between \$101.50 and \$112.50.

There is a great variation in the schedule of free meals; in Baltimore a high percentage received two meals a day and rooms, while there are few such benefits for any type of workers in Portland or Minneapolis.

Only in Atlanta and Memphis do a majority of nurses and white-collar employees work more than 40 hours a week, yet Atlanta has no split shifts, in contrast to most other cities.

NOTES:

Public Health Service and American Medical Association are in conflict over Asian influenza vaccine dosages; a P.H.S. advisory committee recommends a full cc. given subcutaneously, with smaller dosage for children; an A.M.A. advisory committee says the doctor should decide whether to use a full cc. subcutaneously or 1/10th of a cc. intracutaneously. If most doctors would decide on the intracutaneous method, the shortage of vaccine would become a surplus in a few months.

Word has gone out that there will be no more Inter-Agency Hospital Institutes, which for a number of years have brought together federal hospital people for seminars and lectures. It is understood the military medical departments arranged to end the institutes, believing they could bring the same information to their own people at less cost in time and money. There has been no official announcement yet, and the decision could be reversed.

Joint Blood Council has issued a pamphlet, "Standards for Accreditation of a Blood Transfusion Service," by means of which institutions may "voluntarily accredit themselves." A joint product of the council and the American Association of Blood Banks, it adheres to the National Institutes of Health requirements and includes guidelines for compatibility testing and recipient identification. Copies are available at the council headquarters, 1832 M St. N.W., Washington 6, D.C.

Another Joint Blood Council publication, a progress report on its survey of blood facilities, shows that in calendar 1956 a total of 4,585,000 transfusions were given to about 2 million patients. The council now is mailing out the final questionnaire in its survey.

Administration and congressional leaders in medical fields are repeatedly calling for enactment next year of legislation for federal construction aid to medical schools for teaching facilities.



LOOKING AROUND

Choice

SOME wit said that a committee can't drive a truck, and the observation has been used to argue that democratic methods don't work when somebody has to deliver the goods. Like many attractive analogues, this one is only partly true. A government that derives its authority from the consent of the governed necessarily bows to majority rule, at whatever sacrifice of prompt delivery of the goods, because in public affairs preservation of the system is more important than achievement of the result.

In a private institution or business, the reverse is true. Here management is charged with responsibility for the result, using whatever system it chooses. In many institutions and businesses today, executives choose to give employees a voice in management, but only woolly-headed executives persist in this choice at the sacrifice of long-term institutional results, and private management is at liberty to choose autocratic or even dictatorial methods, as long as individual legal rights are not violated.

What is the right method for managing the affairs of a membership association that has both public and private characteristics and responsibilities? By its own constitution, such an association commonly gives govern-

ing authority to a representative body, but, because the representatives meet infrequently and have other primary interests, practical authority resides in an executive group that is virtually self-perpetuating. Ultimately, as in government, the executives must be responsive to the desires of the membership, but in practice the effectiveness with which such desires are expressed may be determined largely by the methods chosen by the executive authority itself. Thus the officers and executives of an association must decide for themselves, again and again, whether they shall act to preserve the system, as government must, or to achieve results, as private management does.

The choice is philosophic. In a professional field beset with problems, only a strong-willed devotion to the democratic principle will prevail against the misgiving that "in a representative democracy the Demosthenes whose counsels would have saved the nation might be unable to obtain a seat."

Hallelujah

PARTLY because of a naturally cranky turn of mind and partly from a conviction that the critic serves society better than the psalm singer, this department is discovered counting the debits more often than the cash.

Especially as we have contemplated hospital convention practice over the years, we have notably refrained from throwing hat in air and have found occasion, instead, to point out that there are too many conventions and too few good ones—too much shouting and too little learning.

Reviewing the hospital convention in Atlantic City last month, however, we must acknowledge that the balance there was overwhelmingly on the side of the angels. From a reporter's notebook, here are some of the credits:

At a committee meeting, a group of hospital executives calmly discussed the pros and cons of proposals to seek government aid, on the basis of the job to be done and the merits of the proposals. The word "socialism" was never mentioned.

In a series of meetings on management problems, the best paper of all was presented, not by the industrial consultant, nor by the professor of management, nor by the business school dean, but by the hospital administrator.

In case-history sessions that might easily have become orgies of self-congratulation, several speakers, recognizing that failure is generally more instructive than success, frankly reported ideas and programs that flopped.

A meeting on accreditation had to

be moved from the scheduled room to a larger hall to accommodate 200 administrators who came to hear Dr. Kenneth Babcock describe the rôle of the administrator in accreditation: adviser and helper to the medical staff, not watchdog or policeman.

Several hundred administrators got up early to attend a breakfast meeting where medical authorities laid down the law for preventing hospital infections: scrupulous sanitation.

A couple of hospital visitors from abroad talked excitedly about medical programs and administrative methods they had seen in American hospitals, never once exclaimed, "Of course, your hospitals are so much richer than ours!"

Everywhere one met administrators who said, "I want you to meet the president of my board. . . ."

As at conventions of physicians, scientists and educators, university-related groups made themselves felt with special meetings, announcements, social events.

At a press conference, A.H.A. President-Elect Ray Amberg said hospitals must accept responsibility for nursing home patients and nursing home management.

The hospital industry exhibit, largest on record, displayed hundreds of specific answers refuting the charge that hospitals are less efficient than business.

Nobody bemoaned the hospital administrator's low estate; nobody apologized for hospital costs; nobody wept about bad public relations.

Wrong Answer

MANY hospital administrators say they don't want doctors explaining hospital bills to their patients. "I don't think the doctor should try to explain hospital costs, or management or financial policies, to his patients," one administrator said. "I'd rather have him tell his patients to come to my office, and let me explain."

Why? The hospital patient commonly holds the doctor primarily responsible, if not solely responsible, for everything that happens to him in the hospital. If he doesn't like something about his hospital bill, the doctor is likely to hear about it before the cashier does. The hospital patient un-

derstands vaguely that somebody downstairs is responsible for the business affairs of the hospital, but in most cases he looks for all the answers from the man he knows and trusts—his doctor.

Now, if the doctor knows the right answers, he'll tell them, and that is the end of that. But if he doesn't know the right answers, because the hospital administrator doesn't want him to know, everything is likely to get fuzzy. The doctor may answer the questions anyway and give his patients wrong information, or, worse yet, he may shrug the questions aside with a gesture that says, in effect, "What can you expect from these incompetent clowns?"

He may, of course, tell his patients to take their questions to the office, as the administrator has requested, but the chances are they won't go. Instead they take their resentment and their misinformation and go home and talk it all over with their friends and neighbors, and the hospital has overlooked a basic opportunity to do a public relations job—through the doctor.

The reason usually given by administrators who don't want the doctors to talk about hospital bills is that doctors don't understand business problems and are likely to give wrong answers. This seems a poor reason for not telling them what the answers are, when the alternative is not telling them anything at all, and they're going to answer the questions anyway.

Better Bother

ACCORDING to a recent bulletin from the American Society of Anesthesiologists, some hospital administrators are still dragging their heels on conductive operating room floors. Some administrators, surgeons and anesthesiologists, the society reported, feel that control of static electricity is not practical because of many inevitable irregularities and intangibles, such as failure of personnel to wear conductive shoes, even when conductive floors are installed. "They say that pathologists, radiologists and others wearing wool trousers constantly enter operating rooms," the society bulletin said, "and new materials, unchecked for their susceptibility to static charge, often find their

way into anesthetizing areas. They call attention also to the great hazard of shock from defects in electric circuits and appliances when low resistance floors are in use."

This it-might-not-work-anyway-so-why-bother attitude is strictly for children and psychopaths. Conductive floors are expensive, all right, but so are lawsuits.

V.A. Ahead

THE Veterans Administration, a leader in the development of forward-looking programs for mental patients, recently reported the establishment of a "motivation ward" at one of its hospitals. Patients on the ward are free to take jobs, attend movies and live much as they would outside the hospital, it was explained. In two years, the program has doubled the number of discharges from the hospital, the V.A. reported.

The V.A. experience is in contrast to traditional mental hospital methods under which patients were confined, guarded and frequently neglected therapeutically. Unfortunately, some of the traditional methods persist, not only in state and private mental hospitals, but in some of the 600 general hospitals with psychiatric units. In some of these hospitals, the many advantages of providing psychiatric treatment in the general hospital setting are ignored, and the psychiatric ward is isolated, like a walled fortress, from the rest of the hospital. Where this walled-fortress concept exists, the medical or surgical patient with an emotional problem derives no benefit from the presence of psychiatrists on the staff, and a psychiatric patient with a broken leg or pneumonia might get cared for quicker in Siberia.

The sad truth is that we have not come very far yet in the struggle to recognize mental patients as sick people needing hospital treatment and not as social outcasts to be shunned and feared. After all that has been said on the subject, less than 10 per cent of our general hospitals even accept these patients—a circumstance which suggests that it may be doctors and hospital administrators, and not the general public, who have the most to learn about mental illness.

Are You Ready to Treat Cardiac Arrest?

Sudden death on the operating table must be anticipated in every hospital where surgery is performed, say the authors, and it is the duty of the hospital to insist that everyone on the surgical team be practiced in the art of cardiac resuscitation, a standardized and proven technic. The types of cardiac arrest are defined here and a treatment procedure is outlined. The authors suggest a definite training program for members of the staff, list necessary equipment, and describe the surgical procedure. Post-resuscitative care and a discussion of what to tell the family also are included.

HERSCHEL E. MOZEN, M.D., and CLAUDE S. BECK, M.D.

IT HAS been estimated by the U. S. Public Health Service that approximately 10 million surgical operations are performed in this country each year. Every operation is of vital importance to the persons involved. To the patient about to be anesthetized, there is no "minor procedure." When we consider the fact that sudden death may occur during one in every 1000 to 2000 operations and that the total number of cases of cardiac arrest is about 10,000 annually, the implications are clear and sobering.

We have a duty to society to prepare ourselves, our hospitals, and our staffs to handle these emergencies properly. We cannot adopt the false security of believing that the catastrophe of cardiac arrest is something that happens to other surgeons' patients at other hospitals. The experience of having a patient die suddenly during the course of a surgical operation may be

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Dr. Mozen is chief resident in thoracic surgery at Sunny Acres Hospital, and Dr. Beck is professor of cardiovascular surgery at Western Reserve University.

This is the second in a series of articles concerning the impact of heart surgery on hospitals. The third article will be presented in a subsequent issue.

anticipated by every surgeon at some time during his career.

The problem has been discussed extensively in the medical literature. The purpose of this article is to define clearly the basic concepts and requirements for successful resuscitation of the heart when the need arises. Many members of the hospital team—nurse, anesthesiologist, surgeon and administrator—have important duties and responsibilities before, during and after the emergency. These will be detailed.

DEFINITIONS

The term "cardiac arrest" means the sudden occurrence of death resulting from the cessation of effective pumping action of the heart. It does not apply to cases of fatal illness or trauma where, obviously, the stopping of the heartbeat is merely the terminal pre-mortem event. Cardiac arrest occurs unexpectedly. The diagnosis is made by noting the disappearance of pulse, blood pressure, and heartbeat. The respirations usually cease simultaneously. The skillful anesthesiologist checks these vital signs at frequent intervals and is aware immediately of any abnormality that may herald the onset of an arrest.

If the patient's heartbeat is monitored throughout the operation by

means of a cardioscope or other device, the instant of cessation of cardiac activity will be noted and effective therapy may be started promptly. However, valuable time must not be wasted in obtaining special apparatus to confirm clinically evident findings.

For a long time it has been known that death resulting from cessation of the heartbeat may occur in two ways. One of these is the development of a complete lack of heart activity called *cardiac-standstill* or *asystole*. In this state the heart is dilated, flabby and without rhythmic contractions. (Occasionally, it may stop in a state of continual contraction, *i.e.* systole.)

The second type of cardiac arrest is called *ventricular fibrillation*. In this type of death there is the abrupt onset of a convulsion of the heart, which is converted into a squirming mass of muscle with no purposeful contractions. Though the heart is very active during fibrillation, no blood is being pumped out to the brain, coronary arteries, and other vital structures.

The type of death resulting from ventricular fibrillation is important since it accounts for most of the high mortality of coronary artery disease. Frequently these deaths are very sudden. A fatal attack may occur while a man is shoveling snow, while

he is playing golf, or while he is asleep. Each of us has been shocked to read newspaper reports of supposedly healthy individuals who have "dropped dead." These persons die because the distribution of oxygen through the coronary arteries is uneven, and they develop fatal heart convulsions or ventricular fibrillation.

Naturally, the question arises as to whether some of these persons might

be resuscitated successfully. The answer is Yes. This problem of restoring the heartbeat in patients who die suddenly outside the operating room and yet are within the immediate reach of medical facilities is in a developmental phase. There are several reports in the medical literature concerning patients who have died and then have been restored to life by prompt and effective action. The future possibilities of cardiac re-

suscitation are increasing constantly. When the heart stops unexpectedly during an operation, the surgeon should make every effort to restore its normal activity. The sum of such effects is encompassed within the procedure of *cardiac resuscitation*. A more specific definition is: "Cardiac resuscitation means the full and durable restoration, in due time to avoid eventual death, of the essential functions of a heart

THIS NEW IDEA FOR THE OPERATING ROOM WOULD REDUCE "CLUTTER"

IN OUR studies of existing operating rooms, all of which are quite similar, we wondered if something could be done to make these areas safer, more convenient, and more efficient. The clutter and confusion, inadequate lighting, and inconvenience of facilities seemed to us unsightly, hazardous and unnecessary.

Our aim in the design presented on these pages is to make the operating room a better place in which to work, by bringing neces-

sary services as closely as possible to the point of use, to take as much off the floor as possible, and to provide operating lights that are the ultimate in flexibility.

Each of the three posts carries oxygen, suction, electricity, an operating light and removable tables, and supports an intravenous track. In our observation these posts should be on a circle about 12 feet in diameter.

Thus the circulating area could be kept free of hoses and cables,

I.V. stands, portable lamps, and many tables. These posts would not, in our opinion, be obstacles, since they are placed where normally there is the corner of an instrument table, and the anesthetist.

A number of surgeons and technicians have seen our design; reactions varied from enthusiasm, generally on the part of younger men, to skepticism by others. Presented below are the views of one surgeon who commented critically, together with our replies.

CONSULTANT'S CRITICISM

1. I am not aware of any inadequacy in operating room lighting at the present time. Thus, the added flexibility of lights based on posts, as they are shown, seems to me unnecessary.

2. While I am aware of some "clutter" in the operating room, as you have described it, I do not think many surgeons regard this as a serious problem. On the other hand, I do think that the proposed posts themselves would add to, rather than detract from, such "clutter," and would make the floors harder to clean following operations. In addition, difficulties might be encountered in keeping the posts themselves clean, as well as the overhead track for the intravenous apparatus and other new equipment that has been introduced in this plan.

3. Finally, may I point out that various sizes and arrangements of instrument tables and trays are needed by the surgeon and his assistants, and by the anesthetist, for various procedures. The location of the posts might on occasion interfere with needed flexibility in the arrangement of these tables and trays.

ARCHITECTS' REPLY

1. Operating room lights, in our experience, seem always to be a subject of concern. Many surgeons are constantly experimenting with new arrangements in an attempt to achieve better performance. Manufacturers of this equipment, who also are experimenting, furnish a number of types of lights, any one of which may be adequate within a limited range. We know of none, however, that can offer such an extreme coverage of the field of operations as does the proposed design.

2. There always will be a certain amount of clutter in an operating room, but the degree to which it becomes a problem is a matter of opinion. We think that much of it is undesirable and unnecessary, and have attempted to minimize it. The posts, which are the source of supplies within arm's reach, are located so as not to interfere with operative procedure. The argument about cleaning difficulty puzzles us; we cannot see that the problem is worse than at present. It should, in fact, be better since some equipment has been taken off the floor.

3. It is our intention that all tables and trays on the posts shall be removable and interchangeable. This would allow selection of appropriate equipment for each operation. Supplemental tables and equipment would undoubtedly be needed in many cases, but we believe the posts need not conflict with their arrangement.

which has lost its power to propel blood, and which, in all appearances, is unable to recover its inherent value as a pump, spontaneously." (Fauteux)

PREVENTION OF CARDIAC ARREST

Simply because cardiac arrest may happen without warning does not mean that every effort should not be expended to prevent its occurrence. We do not understand all of the factors involved.

Basically, however, there is always some disturbance in the proper oxygenation of the heart muscle, the myocardium.

Sometimes this may be due to coronary artery sclerosis. We know that patients with this disease can and do undergo major surgery daily. However, the surgeon and anesthesiologist must be especially alert in such cases. Hypotension and anoxia must be avoided. A patient with chronic pul-

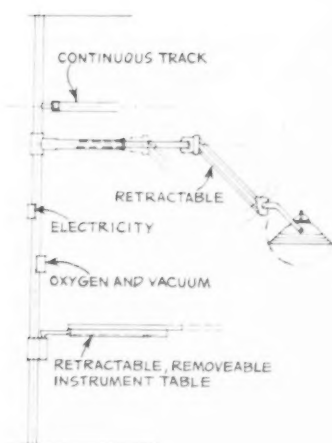
monary disease and decreased vital capacity is unable to oxygenate his blood as rapidly or as completely as a normal person. Extra caution is indicated in such situations. Patients with low blood volume are unable to transport a full allotment of oxygen even though their broncho-pulmonary system may be normal. Here, preoperative blood transfusions are necessary.

The patient should be in the best

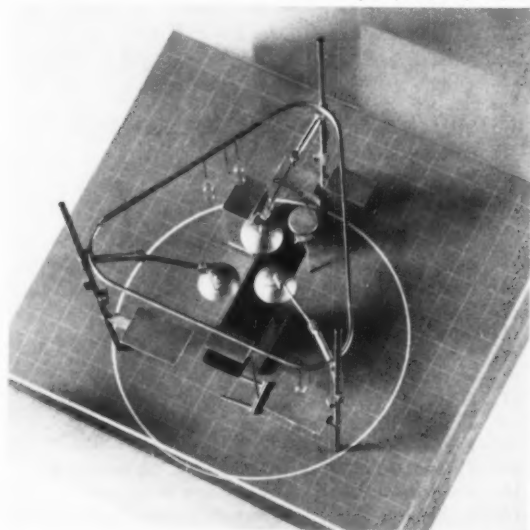
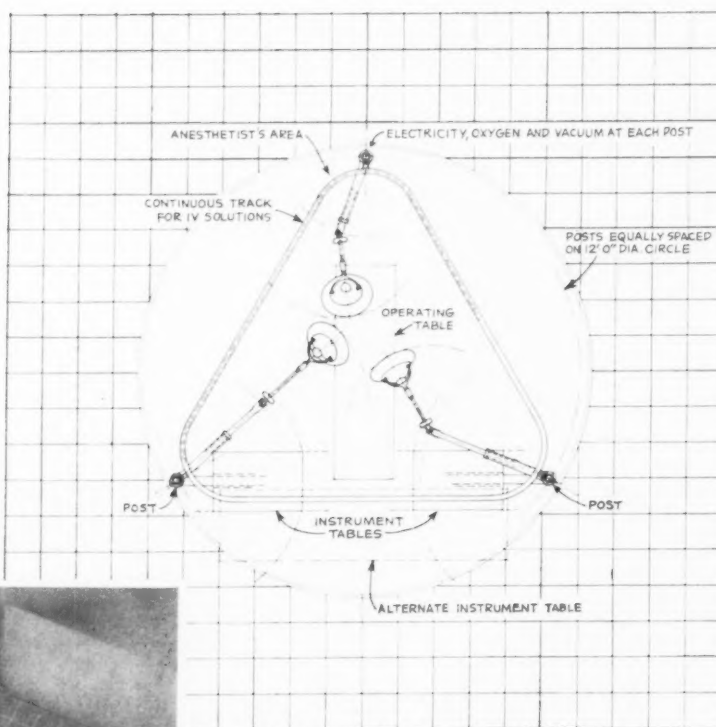
—OR WOULD IT?

EDWIN G. JOHNSON and JOHN M. WHITCOMB

Architects, Cambridge, Mass.



Above: Diagram of one of the posts showing position (from bottom) of table, oxygen and vacuum, electricity, lights and continuous track.



Left: Photograph shows how three posts carrying lights and other equipment, and joined overhead by continuous track, would look in operation. Above: Diagram indicates position of instrument table and alternate and anesthesiologist's area in relation to operating table. Three posts are equally spaced on a circle.

Fig. 1. This easily portable defibrillator operates on 110 volts, A.C. The electrodes of the machine are removable for sterilization in an autoclave for 15 minutes at 250 F. With this apparatus, which should be in every operating suite, fibrillation is converted to standstill and a sustained heartbeat then can be established with relative ease.



possible physical condition prior to operation. He should be prepared psychologically, also. The almost hysterical patient who states that he will not survive a surgical procedure frequently voices an accurate prediction.

During the operative procedure the anesthesiologist must be alert constantly for abnormal signs. Blood loss should be replaced accurately. Hypotension is counteracted with vasopressors if necessary. Evidence of excessive vagotonia is treated with repeated adequate doses of atropine. Tachycardia and acute cardiac failure usually will respond to intravenous digitalis. Tracheal suction may be used to maintain the always indispensable clear airway. The surgeon and his assistants should be aware of the lack of tissue bleeding and cyanosis. These danger signals must be heeded. Certain manipulations, such as dissection of the hilum of the lung and traction on the mesentery, may produce noxious stimuli and should be discontinued immediately if untoward signs appear.

Occasionally, in spite of all precautions taken before and during an oper-

ation, the heart will stop suddenly. When the heart stops, an emergency exists. Blood and oxygen no longer are being delivered to the brain, which begins to degenerate immediately. If effective oxygenation is not restored to this vital organ within the brief period of 3 to 5 minutes, the patient will die. "Any heart which is essentially normal and stops beating during an operation can be resuscitated if it is handled properly." (Beck)

TREATMENT OF CARDIAC ARREST

Every physician who undertakes to perform a surgical operation should be thoroughly familiar with the technic of cardiac resuscitation. The essentials must be mastered in the animal laboratory. Anesthetized dogs are used for practice drills, which should be held at regular intervals so that all personnel will be prepared when a real emergency occurs.

The operating room personnel needs preliminary training as to its supporting rôles in such cases. The first requisite, of course, is an experienced and interested surgeon, who is willing and

able to proceed with the training of his assistants and other personnel.

Under the sponsorship of the Cleveland Heart Society, one of us [Dr. Beck] has conducted a course in cardiac resuscitation for almost 10 years. The co-director of the course is Dr. Robert Hosler, who has written a manual on cardiac resuscitation that can serve as a textbook for such courses.

Several hundred surgeons, anesthesiologists, operating room nurses, and even laymen have completed Dr. Beck's two-day course. Each is required successfully to bring a dog's heart out of ventricular fibrillation at least once. We know of many patients who were resuscitated successfully as a direct result of instruction received in this course, and many of the course graduates are now working in hospitals where routine programs for the prevention and management of cardiac arrest are being carried out.

If a formal course cannot be organized, we suggest that the entire staff gather in one of the operating rooms—early on a Sunday morning is an excellent time—and there, using anesthetized dogs to represent patients, go through the entire sequence of stopping, starting and defibrillating the dog's heart. This should be done over and over again until everyone understands the process.

Nurses, internists, anesthesiologists, lay administrators, all can be taught how to perform cardiac massage and how to insert an endotracheal tube to provide oxygen to the lungs. A medical degree is not a prerequisite to being able to resuscitate a stopped heart.

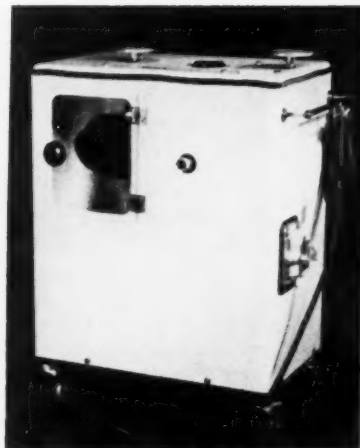
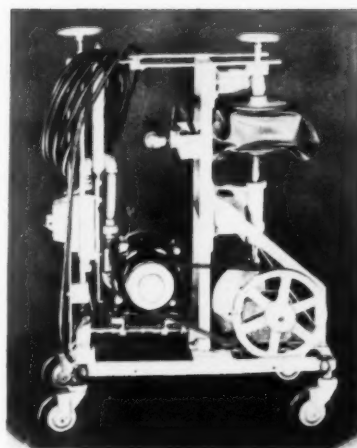
DRUGS ON CARDIAC RESUSCITATION TRAY

1. Adrenalin (epinephrine) solution, 1:1000, 1 doz. 1 cc. ampules
2. Procaine hydrochloride solution, 1 30 cc. vial (1 per cent)
3. Cedalanid (lanatoside C, intravenous rapid acting digitalis preparation) 1 doz. 2 cc. ampules
4. Pronestyl (procaine amide solution) 2 10 cc. vials
5. Atropine sulfate solution, 1 25 cc. ampule
6. Hydrocortisone, 3 100 mgm. ampules
7. Quinidine sulfate solution, 1 10 cc. ampule
8. Ephedrine sulfate solution, 6 2 cc. ampules
9. Neosynephrine solution, 1 10 cc. vial
10. Levophed (norepinephrine) 6 4 cc. ampules
11. Wyamine, 1 30 cc. vial
12. Malar lactate solution, 2 100 cc. ampules
13. Insulin, U40, 1 10 cc. vial
14. 50 per cent glucose solution, 2 100 cc. vials
15. 6 each of 5 cc., 10 cc., 25 cc. syringes; 2 50 cc. syringes
16. 6 each of 2 inch No. 16, No. 18, No. 20, No. 22 needles. 6 1/2 inch No. 24 and No. 26 needles
17. Tourniquets

INSTRUMENTS ON CARDIAC RESUSCITATION TRAY

1. Portable defibrillator
2. Scalpel and sharp blade
3. Endotracheal tube, connections, tank of oxygen (portable)
4. Sterile self-retaining rib-spreader
5. Kelly clamps, 12
6. Hemostats, 12
7. Moynihan clamps, 6
8. Long dissecting scissors, Metzenbaum, 1
9. Suture scissors, 2
10. Needle holders, 2
11. Blade retractors, various sizes, 4
12. Satinsky clamp, 1
13. Beck aortic clamp, 1
14. Chromic sutures, various sizes, 0, 20, and 3 0
15. 4 0 silk sutures for skin closure
16. Sterile linen; towels, 12, half sheets, 6, laparotomy sheet, 1
17. No. 30 chest drainage tubes, 2
18. Underwater drainage tubes, bottle and connections

Fig. 2. Two views of a mechanical respirator, which is recommended for any case in which adequate pulmonary ventilation is required. At the far right the respirator is shown covered. The ventilation maintained by a mechanical respirator is similar to that which may be produced by manually exerting pressure on a breathing bag, i.e. the lungs are inflated slowly and allowed to deflate without resistance. The cycle of respiration is the same as that in normal deep breathing. Mechanical ventilation is more effective and frees the anesthesiologist's hands for other duties.



As has been noted, we have arrived at the point where a surgeon should be expected to understand and be able to apply the technics of cardiac resuscitation, when necessary. The hospital should be expected to provide the necessary apparatus to do the job properly.

It should be the hospital's responsibility to provide the following equipment for possible use during every operation:

1. Endotracheal tube to establish a clear airway.
2. Oxygen and a rubber bag to ventilate the patient mechanically.
3. Scalpel to open the chest.

A defibrillating apparatus should be available in every operating suite. A number of such devices are manufactured by different concerns. Such an instrument will deliver an electric shock to the heart of 110 volts at 1.0 to 1.5 amperes for 1 second. Such a shock causes a tetanic contraction of the heart and the abolition of all activity. Fibrillation is converted to standstill and a sustained heartbeat then can be established with relative ease.

By squeezing oxygen out of a rubber bag by hand, a person can pump oxygen into the lungs. Mechanical ventilation is more effective and frees the anesthesiologist's hands for other activities. A mechanical respirator for cardiac resuscitation and for all operative procedures in which continuous adequate oxygenation is desired should be a part of the equipment.

RESUSCITATION IN TWO STEPS

The basis of successful cardiac resuscitation is the appreciation of the fact that the procedure is divided into two separate and distinct steps. These are: (1) *restoration of oxygen system*, an emergency act that must be accom-

plished within from 3 to 5 minutes, and (2) *restoration of coordinated heartbeat*, which may be accomplished deliberately and may take place over a period of several hours after the oxygen system has been reestablished, in some unusual cases.

As soon as cardiac arrest occurs, Step 1 should begin *immediately*. Each member of the operating room team has an individual rôle to play in this critical drama.

The anesthesiologist: (1) inserts an endotracheal tube at once and provides a clear airway; (2) establishes continuous adequate oxygenation, using 100 per cent oxygen delivered to the lungs under positive pressure at a rate of 20 or 30 respirations per minute, and (3) observes the lungs for adequate inflation and deflation during each respiratory cycle.

During Step 1, the anesthesiologist provides oxygen and artificial respiration.

The surgeon has an equally important duty which is performed *simultaneously*. (1) He proceeds automatically with a preconceived and carefully rehearsed plan of action; (2) he opens the chest widely, without regard for asepsis or bleeding (no blood pressure), through the left fourth intercostal space from the sternal border to the mid-axillary line, and inserts a rib-spreader to prevent fatigue of his wrist from pressure of adjacent ribs; (3) he circulates oxygenated blood by rhythmic manual cardiac compression ("massage") with one or both hands at a rate of 60 to 70 per minute so that a palpable peripheral pulse is produced.

It is important to release the heart after each compression so that adequate venous filling may occur. *The*

correct technic of rhythmic cardiac compression can be learned only by practice.

During Step 1, the surgeon provides artificial circulation of oxygenated blood.

Once the anesthesiologist and surgeon have accomplished their particular duties, the patient may be kept alive indefinitely and the emergency is over. The following ancillary procedures then may be performed.

The surgical assistants: (1) provide retraction and exposure; (2) relieve the surgeon if he becomes fatigued; (3) establish a reasonably sterile field without interfering with essential activities.

The scrub nurse: (1) provides necessary instruments; (2) provides drugs for intracardiac administration.

The circulating nurse: (1) observes time sequences from the onset of cardiac arrest to the beginning of adequate mechanical circulation to the restoration of the coordinated heartbeat; (2) makes certain that intravenous infusion is running; (3) provides additional equipment and drugs as needed.

Step 2, the restoration of the coordinated heartbeat, is accomplished deliberately at any time after the oxygen system has been reestablished. If the pericardium prevents satisfactory emptying of the heart, it should be opened from base to apex and the heart grasped directly. If the heart is in standstill, frequently it will begin to beat spontaneously as soon as oxygenation and mechanical circulation have been started. If the cardiac massage is performed correctly, the coronary arteries and myocardium will become well oxygenated and pink. Sometimes, from 3 to 5 cc. of 1:1000

solution of epinephrine, diluted 10 times with saline, must be injected into the right ventricle to restore myocardial tone. Repeated injections of this drug may be necessary. Occasionally, such injections into the heart may throw it out of standstill into fibrillation.

If the heart is fibrillating, it is necessary to defibrillate it. However, a well oxygenated myocardium with good tone must be present before defibrillation is possible. It is useless to shock a dilated, flabby and cyanotic heart. After the heart is properly prepared by massage and after the application of 3 to 5 cc. of 1 per cent procaine hydrochloride to the epicardial surfaces and the injection of a similar quantity of this drug into the right ventricle, the electrodes of the defibrillator are placed over as large a surface of the myocardium as possible. A standard shock (110 volts, 1.0 to 1.5 amperes, 1 to 2 secs.) is administered. If conditions are right the heart will convert from fibrillation to standstill, which is handled as described previously.

Once the heart has resumed its coordinated beat, further manipulation and drug administration should be avoided. If beginning contractions are feeble, assistance may be given by additional rhythmic cardiac compression as needed.

The heart should be observed for from 20 to 30 minutes to make certain that the beat will be sustained. Chest wall hemostasis may be secured during this period. The pleural cavity should be aspirated completely and antibiotics instilled. A chest tube is inserted for drainage. The pericardium should be closed tight enough to prevent herniation of the heart, or it should be left wide open. The chest wall is closed in layers using absorbable sutures throughout. If resuscitation has been started promptly and performed correctly, the patient usually will be awake by the end of the procedure. Additional anesthetic agents may be necessary.

POST-RESUSCITATIVE TREATMENT

After the heartbeat has been restored and the chest has been closed, three different results may be expected. The first and most desirable is the complete restoration of cardio-pulmonary activity with no brain damage and with a complete return to normal. This result depends upon correct treatment of the arrest.

The second result, and one that oc-

curs far too frequently, is the satisfactory resumption of normal heartbeat but with so much anoxic brain damage that death occurs several hours later. This is due to a failure to restore the oxygen system within the critical time limit.

The third type of result, which is extremely rare, yet prevents many surgeons from attempting resuscitation, is the permanent restoration of cardio-pulmonary function but with such a degree of brain damage as to leave the patient in a decerebrate condition. In most instances, it is impossible to predict when such a result will occur.

Close observation is necessary for several days. Oxygen is administered by nasal catheter. Large doses of broad-spectrum antibiotics are given. If the patient has evidence of cardiac failure digitalis preparations are indicated. In almost every case of complete recovery from cardiac arrest the patient is mentally alert within a few hours after the resuscitation. In those cases in which brain damage has been excessive, the patient usually develops a high fever and dies within from 24 to 48 hours. It is unusual for a heart that has been resuscitated successfully to undergo arrest a second time. This is possible, however, and the patient must be monitored closely for such an occurrence and a possible second resuscitation. A number of patients who have developed cardiac arrest have been resuscitated successfully and later have undergone the originally planned operation without difficulty.

WHAT TO TELL THE FAMILY

There always is a question about what to tell the family and the patient in cases of cardiac arrest. There can, of course, be only one answer: the truth. We know there is a risk in every operation, and that a certain number of patients may have a cardiac arrest. The members of the family should have this explained to them as soon as it happens. They should be prepared for the worst possible eventuality.

The relatives should be told that an unexpected catastrophe has occurred, and that the doctor is doing precisely the right thing, and that he will report to the family at once when the outcome is definite.

A surgeon and the hospital cannot, in most instances, be held directly accountable for a cardiac arrest. Nor can an unsuccessful attempt be regarded as unsatisfactory performance. However,

a good effort must be made in every case. The results will depend upon many factors: preexisting disease, hemorrhage, general condition of the patient, experience of the surgeon, and so forth.

SUMMARY

In spite of all possible preventive efforts, sudden death on the operating table may be anticipated in every hospital in which surgical operations are performed. Cardiac resuscitation, unlike many of the recent widely publicized heart operations, is a standardized, predictable and proven technic which should be a required part of the skills of every surgeon. It is the duty of the hospital to insist upon such knowledge being disseminated throughout the surgical staff and to provide the equipment and incentive for prompt, proper therapy of cardiac arrest whenever the emergency arises.

The importance of dividing the resuscitative procedure into its two separate components is fundamental. Restoration of the oxygen system is an emergency. Restoration of the heartbeat may be accomplished deliberately, minutes or hours after the oxygen system has been reestablished.

The technics and suggestions outlined in this article are based on laboratory observations and wide clinical application. If they are followed, a high degree of success in cardiac resuscitation may be anticipated.

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Over-all view of the combined living room-bedroom and dining alcove in one of the Bloomingdale Apartments constructed for evening and night nurses at Montefiore Hospital, New York. This month's cover picture shows another view of the apartment in color.



These Attractive Apartments Attract Nurses

One way to recruit nurses for evening and night shifts, Montefiore Hospital has found, is to provide them with these handsome apartments which rent for \$35 a month

BRIGHT new apartments with comfortable modern furnishings are the result of an effort to ease shortages of evening and night shift nurses at Montefiore Hospital, New York.

The apartments, which opened in March, were made possible by a grant of \$400,000 from Samuel J. Bloomingdale, a member of the board of trustees, in memory of his father, Lyman G. Bloomingdale, treasurer of the first board of trustees.

The shortage of housing for evening and night shift nurses was particularly acute because of the rather isolated location of the hospital. The majority of the nurses were married women living in the neighborhood with their families.

Only evening and night shift nurses are allowed to live in the new building, located on a lot across from the hospital. Each of the 40 furnished apartments rents for \$35 per month, including utilities. No formal leases are required. All but eight of the apartments were rented by early September, according to Dr. Martin Cherkasky, director.

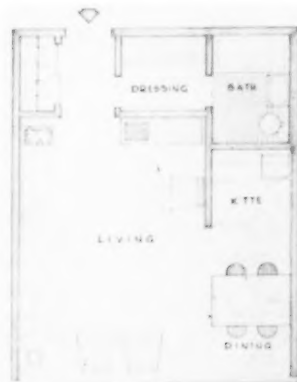
Seventeen new registered nurses have been employed as a result of the living facilities. Ten will work on the evening, or 3 p.m. to 11 p.m., shift; five will work on the night, or 11 p.m. to 7 a.m., shift, and two are employed for the operating room and will work either shift. In addition, 14 new nurses for the day shift have been employed. This is twice the usual fall recruitment, and in large measure can be accounted for by the fact that many of these day nurses are friends of new night nurses and were attracted to the hospital by them. (See Pages 58-59)

FURNISHINGS AND UTILITIES ARE INCLUDED IN THE RENTAL OF THE APARTMENTS



Above: Exterior view of Bloomingdale Apartments, showing nurses' parking area at left. The building is on a lot across from the hospital, and the area is well lighted for the protection of the evening and night shift nurses.

Right: Plan shows compact arrangement of rooms. There are no formal leases, although occupants are expected to vacate when their employment at the hospital ends. Architects were Schuman and Lichtenstein of New York.



Below: The lobby furnishings were deliberately kept simple in order to provide a background for sculpture and paintings. The floor is off-white terrazzo; the sofa is orange, and draperies are beige linen, with orange and red patterns.



Opposite page: Dressing room, located next to the bath, is provided with shelves and closet space. All basic furnishings, as well as utilities, are provided, but nurses are permitted and encouraged to add any individual touches in the way of pictures and ornaments or pieces of furniture they wish.

THERE'S NOTHING OF THE DORMITORY ATMOSPHERE IN THESE COLORFUL QUARTERS

EACH apartment has a 12 by 17 foot living room, 5 foot dining ell, completely equipped kitchen, dressing room, bath, and two large closets. Furniture was selected by the interior decorator, Emily Malino of New York, and a women's auxiliary committee. A daybed, desk and matching chair, easy chair and hassock, coffee table, large marble-topped utility table, chest of drawers, and dining table and four chairs are provided. Most of the furniture is metal and plastic to eliminate maintenance problems. Floors are off-white vinyl tile. A color from the draperies is repeated on the wall behind the dining area; other walls are painted white. The wall behind the bed is papered with washable white textured plastic. Modern prints are hung on the walls, and occupants are encouraged to add their own touches to the apartments.

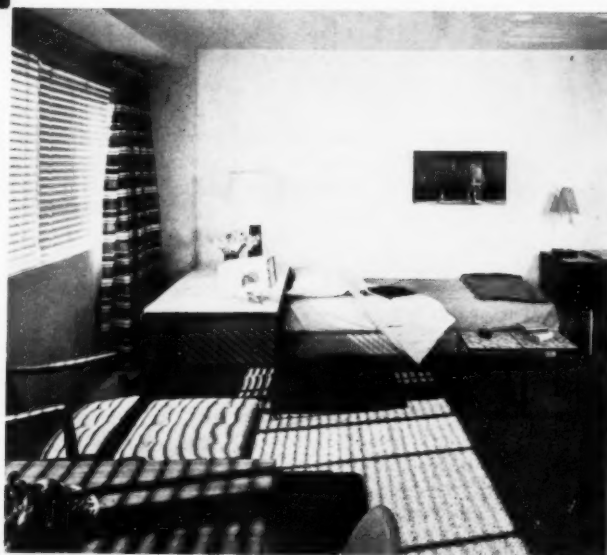


Above: The dining nook has been placed just outside the kitchen for convenient serving. Chairs are white molded plastic on black metal legs. A color from the draperies is repeated on the wall directly behind the dinette set.



Left, thick bolsters make bed comfortable for use as couch. Blue and green draperies are used on southern side of building; orange and red tones are featured on the north. All of the apartments have a picture window.

Below, living room prepared for sleeping. Part of the marble topped table has been closed in to form head-board for the bed. Club chair and rug are black and white tweed. Mosaic tables repeat color of draperies.



Where Nursing Education Standards Are High So Are Applications for Schools of Nursing

The only professions that have made headway in solving their personnel problems are those which have continually raised their educational standards, says this nurse-author in response to the article on "The Five Sides of the Nursing Problem," by Dr. Thomas Hale Jr., published in *The MODERN HOSPITAL* for July. Dr. Hale raised the question of whether nursing education leaders are wise in pushing for higher standards of nursing education when the result is withdrawal of the services of student nurses from patients during the training period. Miss Lorentz, however, cites Dr. Hale's own argument concerning the increasing responsibilities given nurses and the consequent need to educate them to meet these responsibilities. Five recommendations are discussed: adequate salaries; an organization of hospital schools; the accreditation of schools of nursing; establishment of a commission on nursing, and more participation by nurses in discussions of nursing education affairs.

MILDRED LORENTZ, R.N.

I SPEAK from the point of view of a nursing service administrator and a nurse educator. I am deeply concerned with patient care and with the costs of such care, and I am equally concerned with the education of students who enroll in our hospital schools of nursing. My premise is that a hospital electing to operate educational programs undertakes two responsibilities: the care of its patients, and the provision of a sound education for its students, in keeping with the trends in contemporary education.

My hospital administrator is my greatest ally in promoting good standards for the basic nursing program. The hospital administrator who is familiar with standards of good nursing education realizes that good nursing education can take place only in clinical areas where good nursing is practiced. In other fields of medical educa-

tion in hospitals, it has been observed that the presence of teaching programs tends to raise the level of medical care by attracting a better staff and by acting as a stimulant to all hospital personnel who render medical or medically related care to patients. Likewise, the presence of student nurses, practicing under supervision in the hospital units, tends to raise the level of nursing care.

The hospital administrator, therefore, is concerned not only with good patient care but with providing for the school those nursing facilities conducive to good nursing education. He then feels that he is the "middleman" only insofar as the middleman sees the needs and responsibilities of both areas of his nursing department, helps interpret those needs to his board of control, and assists his nursing administrator in providing professionally competent nursing care and a nursing education program of acceptable standards.

The supply of nurses must be considered in relation to trends in other professions and in education in general. Nursing leadership is energetically trying to keep abreast of trends, the while engaging in experimentation in better management of nursing service, in better utilization of personnel, and in curriculum development for the most effective and economical education of nursing students. I believe that the determined effort to bring about improvement of schools of nursing, consistent with trends in the field of education, has been an important factor in attracting a growing number of young people to nursing education.

How has the nursing profession kept pace in numbers compared to other similar professions and in relation to population trends? Have we done better or worse than other professions in the health field? In contrast to the fields of medicine and dentistry, the ratio of nurses to population has shown significant improvement since the pre-war years. In 1956 there were an estimated 450,000 active professional nurses, or 258 nurses for every hundred thousand people. In 1940, by comparison, the ratio of professional nurses to population stood at 216 for every hundred thousand. In 1941, the ratio of physicians per hundred thousand population was 136 while in 1954 the ratio had dropped to 132 per hundred thousand. Likewise the ratio of dentists to population had dropped from 60 per hundred thousand in 1941 to 58 per hundred thousand in 1954.

Nursing has grown and developed as many other professions have grown and developed in their evolutionary processes. The lawyer no longer obtains his experience and education solely through his apprenticeship as a law clerk. Physicians no longer obtain their medical education and experience solely through observation of a skilled practitioner and practice un-

The author is director, department of nursing, Michael Reese Hospital Medical Center, Chicago.

der his supervision. These professions are much older than the nursing profession and sometimes our critics forget that nursing as a young profession is experiencing the same evolutionary changes in its educational program.

If "the hospital is an educational institution par excellence," isn't it imperative for the controlling boards of hospitals and hospital administrators to consider themselves as private school operators, and, in the interests of improved patient care, to provide the best educational programs possible for their nursing students?

CITES HALE ARGUMENTS

Dr. Hale recognizes the growing responsibilities placed on all nurses for more complex care of patients and for direction of a larger number of auxiliary personnel. To discharge such responsibilities, the student of nursing needs to know principles, needs supervised practice in the application of the principles, needs communication skills, and needs a work week conducive to good mental and physical health. Obviously, as content essential to modern nursing education is expanded, the time available for service to hospitals narrows.

Nursing educators have no dream of taking all nursing education out from under the wing of the hospital and establishing all nursing education in institutions of higher education. In its recent publication, "Nurses for a Growing Nation," the National League for Nursing points out that two-thirds (67 per cent) of the professional nurses work directly with people who are ill and that their work is carried out in situations—the hospital or the doctor's office—where supervision or direction is desirable and available. Twenty per cent are head nurses, public health nurses, school and industrial nurses who function with a greater degree of independence. Only 13 per cent of the practicing professional nurses are in leadership positions, as supervisors and administrators in nursing service and as faculty in schools of nursing.

Therefore, if we base our studies on present employment of nurses and if nursing's educational patterns are matched with responsibilities for which nurses need to be prepared, it appears that, within the foreseeable future, 67 per cent of our nurses should be prepared in diploma and associate degree programs, 20 per cent in baccalaureate degree programs, and 13 per

cent in programs beyond the baccalaureate level.

Such studies as "Nurses for a Growing Nation" do not seem, therefore, to indicate that nursing educators are dreaming an unrealistic dream of taking all nursing education from under the wing of the hospital. Nursing educators and nursing service administrators are concerned, however, about the quality of the nursing education programs found in some schools conducted by hospitals.

The president of a large university recently said that the only professions that have made headway in solving their personnel shortages are those that have continually raised their educational standards. In 1956 nursing admissions increased only in college programs leading to a baccalaureate degree. Diploma, or three-year, programs dipped from 39,513 admissions in 1955 to 38,694 in 1956. In general, the collegiate or degree programs are much more costly to the student and her parents than is the diploma program where the student "earns while she learns." The per cent of nursing students enrolled in basic degree programs of the total number of students enrolled in all nursing programs has increased from 5.6 per cent in 1946 to 14.9 per cent in 1956. Do not these facts demonstrate that it isn't the inexpensive courses that are attracting an increasing number of applicants?

ENROLLMENT HAS INCREASED

Although the total number of basic nursing schools and programs has decreased from 1190 schools in 1950 to 1125 schools in 1956, the enrollment of students in the same years has increased from 97,903 in 1950 to 109,904 in 1956. An obvious conclusion is that a decrease in the number of nursing schools does not necessarily mean a decrease in the number of students enrolled. These data probably mean that more applicants are attracted to schools known to maintain high standards.

It is not necessary for "nurse educators to urge guidance counselors in high schools" to direct their students only to those schools that are nationally accredited. High school students are familiar with accreditation standards of schools and colleges; to seek admission to an accredited nursing school is a "natural" for them.

Well prepared teachers and faculty members constitute the greatest area

of nursing shortages, and increasing the number of students in our schools of nursing is directly contingent upon the availability of faculty members who possess the skills necessary to teach nursing. These skillful teachers of nursing, to quote Dr. Hale, "should inculcate in their students ideals, attitudes and motivations based on the service concept, recognizing that this is basic to both medicine and nursing, and once lost is difficult if not impossible to regain." Since these well prepared teachers of nursing are in such great demand, can we blame them for seeking employment in accredited schools where they feel assured that good standards of nursing education will be maintained?

BACKED BY FACULTY

These teachers and educational administrators know that the accrediting program of N.L.N. asks for nothing that a good program should not have. They know that the process of accreditation is not an extraordinary burden to a school. They also are aware that in a nationally accredited school, faculty members constantly review, study and evaluate the program in terms of new needs, purposes and facilities. As faculty members in such schools, they assume their rightful responsibilities in guiding and directing the basic educational programs for nursing students.

In developing the aggressive program of school improvement some nine years ago, the nursing profession considered the counsel of consumers, doctors, nurses, educators and hospital administrators—Dr. Hale's "five sides of the nursing problem." The nursing profession provided for representation from all of these groups in planning and in formulating policy. The executive committee on accreditation policies has representation from the American Hospital Association, the American Medical Association, general education, and nursing. This executive committee advises N.L.N.'s board of directors and has helped guide the development of accreditation. Nursing leadership has not made policies without full advice from other groups whose interest is equal to its own.

In relation to curriculum development and standards of education, we expect such decisions to be made by the educators in each profession. People involved in nursing service rightly define the kind of person they

need to give the standard of service they wish to provide. Educators in all fields determine the body of knowledge and practice essential for the fundamental education of the practitioner. However closely nursing service administrators may be associated with doctors, dietitians, social workers, medical technicians, and hospital administrators, few of them feel well enough informed about the education of these associated groups to make decisions concerning content, methods of teaching, or the experiences that should be included in the basic curriculum to prepare those members of the health team. It is expected by all disciplines that such decisions will be made by the educators in each profession. Therefore, it would seem that it should be the responsibility of nurses, with whatever expert assistance they seek, to determine standards of nursing education and to develop the nursing curriculum.

Our thoughtful critics might consider the adequacy of patterns of education that have brought us where we are. The five-year experiment in junior colleges with a completely reorganized curriculum is nearing completion. The report will be published by G. P. Putnam's Sons around the end of the year. Open-minded study of its findings is indicated before one either condemns or approves this new venture to bring more nurses into practice in the shortest time compatible with sound education.

When the National League for Nursing was organized in 1952, the structure provided for a council of member agencies of hospital schools. In April 1957 this Council of the Department of Diploma and Associate Degree Programs had 412 member schools. The council gives hospital schools an opportunity to work together; it disseminates vital information among its members, and it provides for free exchange of ideas on matters of concern to hospital schools. The council holds annual meetings for member agencies, and each member agency can send two representatives to all meetings. Each representative has a vote on all matters decided by the council.

In this council not only nurse educators concerned with hospital schools and associate degree programs but hospital administrators, members of hospital boards, and other citizens representing a member school have equal voice and vote. In the last meeting of

this organization, held in Chicago in May, 545 representatives of member schools discussed for two full days standards, criteria and problems of diploma and associate degree programs. Relatively few hospital administrators attended this meeting; those who did made valuable contributions to the discussion.

Since hospital administrators, citizens on our boards of control and advisory committees, and nursing educators are all concerned with a common problem—educating nurses sufficient in number, knowledge and skills to give good nursing care for the nation's sick—we agree with Dr. Hale that a countrywide organization such as the Council of Member Agencies of the Department of Diploma and Associate Degree Programs has a significant rôle to play in determining patterns of nursing education for the present and the future.

This council is self-directing in electing its officers and in outlining its program. It makes recommendations for program or policy that influence the board of directors of N.L.N. Membership in the council has increased from 133 member schools in 1955 to 412 member schools in early 1957. As more schools join, broader representation and more effective planning for basic, noncollegiate programs will result.

In summary, I will discuss the following recommendations:

1. Adequate salaries for nurses.

Nurses' salaries in line with contemporary groups and good working conditions. I most heartily agree. From many studies, the quality of supervision and the attitudes of administrators and doctors loom high in providing job satisfaction in nursing.

2. Organization of hospital schools. The agreement of nursing that all schools should have a channel through which they can share in influencing trends of education, its problems, and solutions is evidenced by the fact that the by-laws of the National League for Nursing make provision for such an organization under the name of the Council of Diploma and Associate Degree Programs. The wide participation of schools would seem to indicate that the council offers an opportunity for participation to any school that wishes to become a member of the Department of Diploma and Associate Degree Programs. Accreditation status has no bearing on membership. The council provides the

channel for representatives of schools to discuss its organization if the council is not meeting a need.

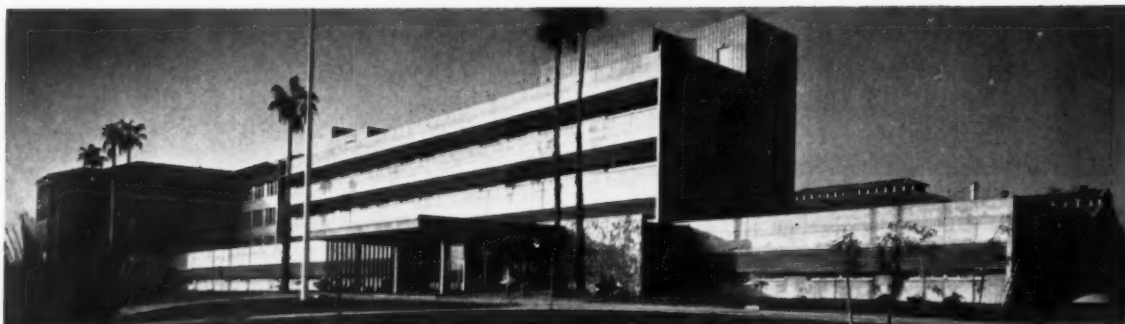
3. Accreditation of schools of nursing. The process of accreditation of programs of nursing education has been used as a method to involve schools in a sustained self-improvement program with professional accreditation as evidence that certain standards have been met. Accreditation of education programs by a commission organized to accredit an institution as a service agency would run counter to the trend in accreditation of programs of education by several professions.

The issues and philosophy that underlie the prerogative of a profession to undertake accreditation are too deep to be discussed here. Sufficient to say that there is broad representation of interests reflected in N.L.N.'s board of directors, its executive committee on accreditation policies, its councils of member schools, and some 75 committees. It seems incredible that such broad representation at the council tables would support an accreditation program with unobtainable standards. A true study of the standards and policies will prove this point.

Untold confusion would exist in the minds of prospective students, their parents, and school counselors if the accreditation of schools of nursing were divided among several agencies. To set apart hospital schools for treatment different from other schools would emphasize separateness rather than a relatedness among the diploma and collegiate programs.

4. Commission on nursing. Whether or not a commission on nursing would move us along faster is debatable. From the many studies already made and some now under way it seems evident that we must keep moving ahead, utilizing the democratic process inherent in nursing's own organizations and in close cooperation with related professional organizations.

5. Nurses speak up. This advice to nurses can be eagerly endorsed. More than 400 diploma school representatives have accepted the channel of the council to speak and to vote. Making full use of existing or of new channels of communication will surely result in better understanding and more effective solutions to what Janet M. Geister in a recent article called "the chronicity of the nurse shortage problem."



Above, Kern County General Hospital, Bakersfield, Calif., showing administration wing at right. Exterior lighting, as shown in view below, is controlled by a preset clock

and goes on and off automatically. An automatic sprinkler system waters lawn and shrubs in the early morning when water pressure is high and loss from evaporation is low.



THE MODERN
HOSPITAL OF
THE MONTH

New Wing Ties the Old Ones Together

When an earthquake forced the rebuilding of a large section of this hospital, the new structure was tucked between the remaining wings to produce a logical grouping of services

JOHN W. DOUBENMIER

FORTY-SEVEN days and several earthquakes after July 20, 1952, we began plans for a new Kern County General Hospital at Bakersfield, Calif.

The damage to the hospital, revealed by the first quake on July 21, became more evident after subsequent shocks. It became certain that we

would have to vacate a large part of the hospital.

Kern County General consisted of four interconnected wings fronting on a main boulevard. Three of the wings—B, C and D—were built of non-reinforced masonry in 1922 and 1932. Service Wing E, built at approximately

the same time to house the laundry and boiler system, was of sturdier construction. Wing A, built in 1938, was of reinforced concrete and conformed to the structural code established at that time. It revealed no great damage.

An inspection immediately after the July 21 shock showed irreparable damage to Wings B, C and D. The outside walls were brick on brick only, with no reinforcement. Obviously, these wings of four and five stories had to be dismantled. The three-story service building could be saved, but it would require structural rehabilitation to bring it to acceptable standards. Wing A could be incorporated in the new structure. (Continued on Page 66)

OUTLINE OF CONSTRUCTION COSTS

Total Project Cost (including Groups 1 and 2 equipment and fees)		\$3,083,048.00
No. of beds	161	
Cost per bed		19,149.37
Total square feet	117,411	
Square feet per bed	729	
Cost per square foot		26.26
Total cubic feet	1,605,082	
Cubic feet per bed	9,969	
Cost per cubic foot		1.92

Mr. Doubenmier is administrator, Kern County General Hospital, Bakersfield, Calif. Architects were Alford and Thomas, Bakersfield, with Walker, Kalionzes and Klinger, Los Angeles, consulting architects. Hospital consultant was August W. Koenig.



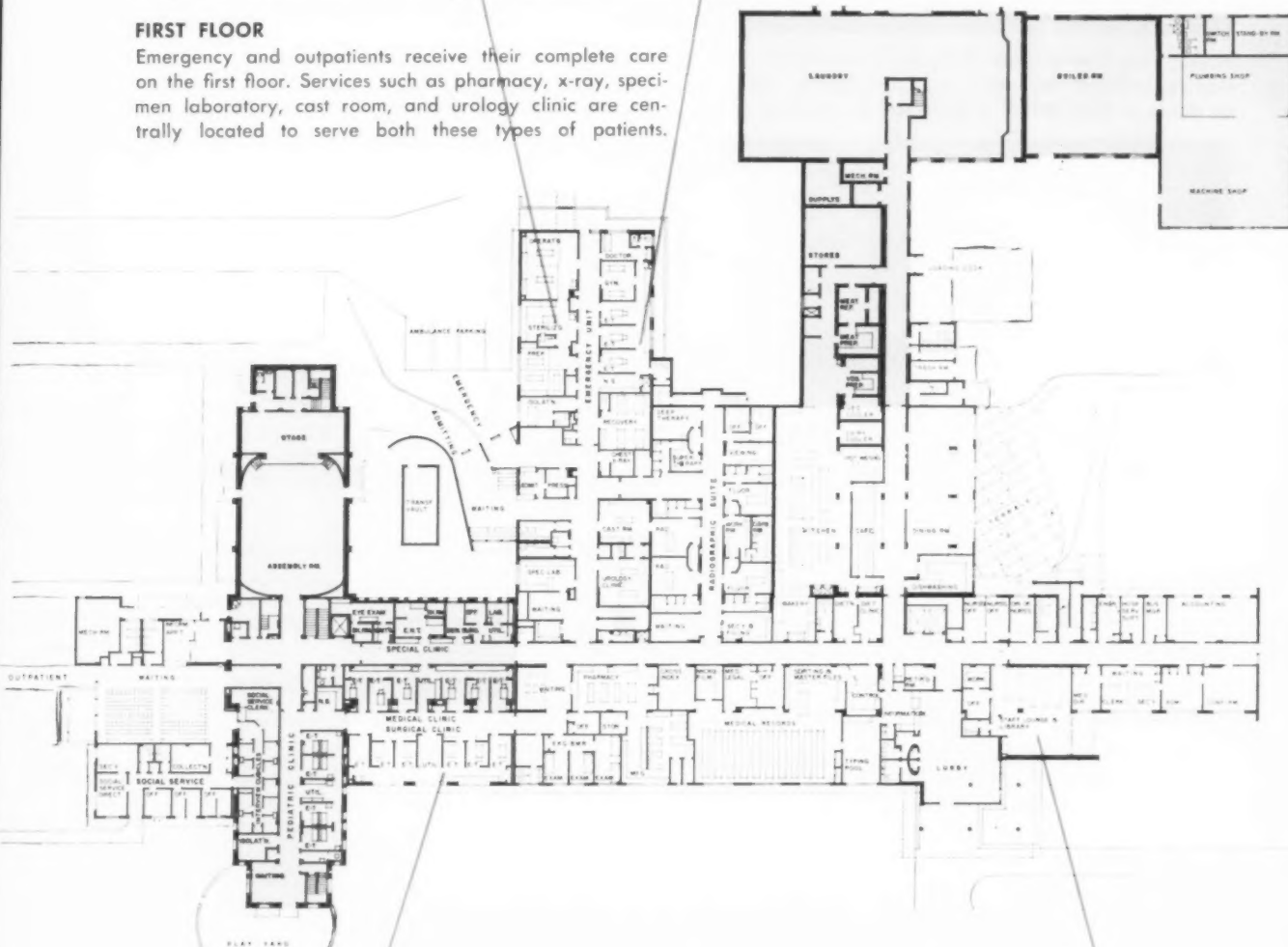
Sterilizing and work area for emergency suite has recessed cabinets for more space. At northwest side of hospital, curved ceramic wall separates emergency entrance into areas for ambulatory and stretcher cases.



Four emergency examination cubicles are located on this corridor, with counters and sinks conveniently near by. Doctors' "on-call" room is at far end of suite; nurses' station can be seen in the foreground of the picture.

FIRST FLOOR

Emergency and outpatients receive their complete care on the first floor. Services such as pharmacy, x-ray, specimen laboratory, cast room, and urology clinic are centrally located to serve both these types of patients.



Examination cubicles for outpatient department. Colored lines in vinyl flooring help patients find way to various clinics. Supervised outdoor play area for well children aids mothers with other children at the pediatric clinics.

Since Kern County Hospital is associated with several training programs, the medical library is essential. Open shelves house 4000 books. On the shelves below picture window are current periodicals of interest in the field.





Central supply workroom, with work island in center. Door at far left leads to glove room. Adjacent surgical suite is served by pass-through window and door at rear of central supply area housing the sterile issue racks.

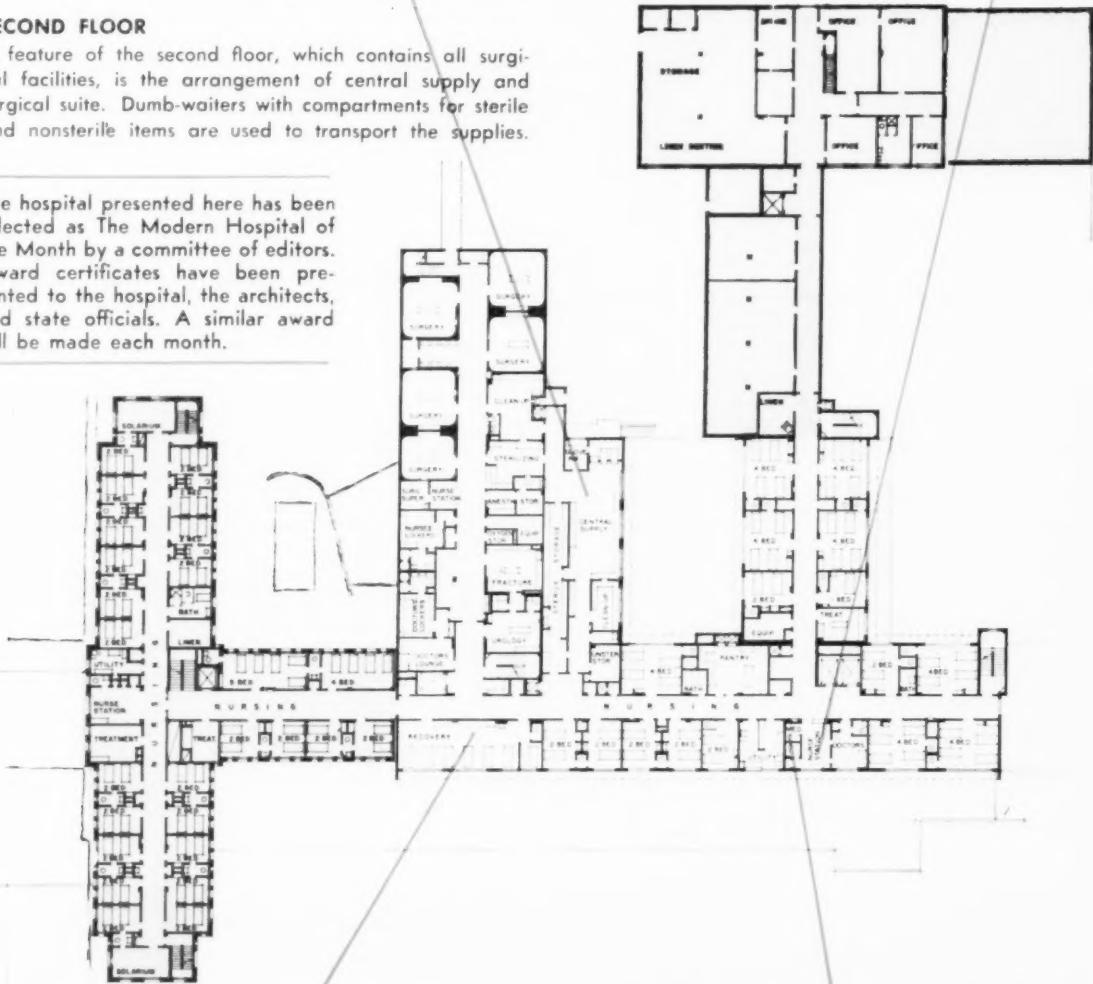


On second and third floor, a doctors' room adjoins the nursing station. Records can be passed between them through a sliding panel window. At right in this station is alcove set aside for medicine preparation and storage.

SECOND FLOOR

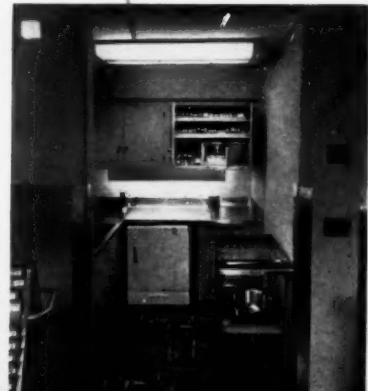
A feature of the second floor, which contains all surgical facilities, is the arrangement of central supply and surgical suite. Dumb-waiters with compartments for sterile and nonsterile items are used to transport the supplies.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and state officials. A similar award will be made each month.



Postanesthesia room has direct alarm to surgery, nursing stations, and anesthetist. Oxygen and suction outlets are at each bed. Room is on second floor, as are operating rooms and surgery wards. All surgical patients are accommodated on this floor in order to decrease the constant use of elevators.

Medicine cabinets, preparation area are convenient to nurses' station. If narcotics cabinet door is opened, the station light at upper left turns on.



(Continued From Page 63)

The damaged area accommodated 253 beds, 48 bassinets, and all the diagnostic, therapeutic and ancillary services of a large general hospital, totaling one of the largest structural losses in American hospital history.

To take full advantage of what remained of our hospital, it was necessary to fit the new construction between Wing A on the west and Wing E on the north.

Rehabilitation of Wing E, demolition of the old structure, and rerouting of utilities were the responsibility of Kern County. The Hill-Burton project was limited to new construction and the complete remodeling of the basement and first floor of Wing A.

We established certain basic goals to guide us in the planning:

1. Give special attention to traffic flow as well as to services. It was our desire to use the most rigid principles of architectural and industrial engineering in planning our building.

2. Adopt the principle of horizontal relationships, so that diagnostic and therapeutic facilities for a given patient would be available to him on the same floor.

3. Capitalize on vertical transportation, with service facilities located either above or below the consuming departments. For example, we located central supply in the same wing with operating rooms, delivery rooms, and emergency.

4. Concentrate diagnostic and therapeutic facilities in one wing of the new building so that major electrical, sterile steam, and plumbing installations would be grouped in the same area for economical construction and efficient maintenance.

5. Give particular attention to the problem of entrances and admissions, by separating the incoming traffic into special areas for each need.

The consulting architects (Walter, Kalionzes and Klingerman of Los Angeles), the administrator, and seven staff members comprised the permanent planning committee. Then, as individual departments were discussed, each department head and his staff were interviewed. Our plans thus reflect suggestions of many persons, both professional and nonprofessional.

Patient accommodations are in two-bed and four-bed rooms. There is only one single-bed room per ward. If more private rooms are needed, a bed in a two-bed room can be removed or left vacant. Since this is a county hospital, with the emphasis on wards, we believe that it is more advantageous to have two-bed rooms that can be used as private rooms than it is to build single rooms that cannot accommodate more beds. Toilets are located between the two-bed rooms to serve four patients. Each four-bed room has its own toilet facilities.

Because of the excessive summer heat in the San Joaquin Valley, it was necessary to install a complete air conditioning system. Common ducts are used for heating and for cooling. The absence of radiators permitted the design of minimum size patient rooms. Fixed aluminum louvers attached to the buildings shield windows.

Exterior walls are unpainted stone-finished concrete, which requires virtually no maintenance. During the life of the buildings, this will amount to a sizable saving.

In conjunction with Bakersfield College, the hospital offers a one-year

training program for licensed vocational nurses. The college also began a professional school of nursing this fall, and these students will receive some training at our hospital. In addition, the hospital is approved for training resident physicians and laboratory technicians.

To aid these educational programs, provision was made for closed-circuit television. The actual TV apparatus will be purchased later, but conduits, equipment rooms, and monitoring windows have been installed. Telecasts can originate from two operating rooms and two delivery rooms and may be viewed from the conference room, the medical library, or from the auditorium, which seats 200.

The one-story administration wing on the east end of the new building was designed to withstand the weight of three additional stories in the future. The architect's master plan provides for construction of another wing at the east end, parallel to Wing A on the west, which would accommodate 150 patients. The added construction would not interfere with existing roadways and parking lots.

In California there has been considerable interest in having county hospitals render long-term therapeutic service to patients with minor psychiatric problems. Should this plan materialize, our 19 bed psychiatric ward, now used for diagnosis only, would prove inadequate. However, adjustable features, such as special door jams, have been installed and electrical outlets and piped oxygen facilities have been "roughed in," so that the ward can be converted to general medical use. Psychiatric facilities would then be added elsewhere.



Separate outpatient entrance and exit at west of hospital keep the nearly 300 visitors per day away from main entry. The parking area for outpatient's also is separate.



Main waiting room at outpatient entrance is supplemented by sub-waiting rooms adjacent to each clinic area. Louvered screen outside glass wall shields room from glare.

How to Set Up Cost Controls for Housekeeping

Study at Cleveland Clinic Hospital outlines methods of determining standards of cleanliness, cleaning procedures, work output, training and supervision in order to arrive at most effective methods of controlling costs of operation

E. J. FREDERICK, J. G. HARDING and DOROTHY SCHWORM

IN AN attempt to employ the methods approach to one large hospital department a complete study of the housekeeping department of Cleveland Clinic Hospital was undertaken. A large building project had made it necessary to add substantial numbers of employees to this department. To justify these additions, the study was conducted with the full cooperation and support of the housekeeping, methods, and administrative departments.

Certain broad management controls give basic information: (1) total area in square feet maintained per employee, (2) monthly and annual labor cost per square foot, and (3) monthly and annual supplies cost per square foot. However, these broad controls do not indicate whether the proper work methods and the proper equipment and supplies are being used. It is imperative to determine how these items can be combined most effectively to obtain maximum results from each dollar invested in housekeeping. This can be done by establishing a cost control program.

ELEMENTS OF CONTROL PROGRAM

A cost control program of the housekeeping department is composed of six segments, as follows:

1. Work quality (standard of cleanliness)
2. Work method (standard cleaning procedures)
3. Work load requirements (schedules of work)

Mr. Frederick is former methods director, Cleveland Clinic Foundation, now senior associate, Cresap, McCormick & Paget, management consultants, New York; Mr. Harding is superintendent, Cleveland Clinic Hospital, and Miss Schworm is executive housekeeper, Cleveland Clinic Hospital.

4. Work supervision (training of employees and follow-up of output and quality of work maintained)

5. Work supplies (standard equipment and supplies)

6. Work interest (employee interest and morale)

WORK QUALITY

The cleaning responsibilities of the housekeeping department may be divided into the following general classifications, or units of work:

1. Cleaning patient areas, such as patient rooms, nursing stations, utility rooms, and other service areas located on the nursing division.
2. Cleaning corridor floors on nursing divisions and in other areas of the hospital.
3. Cleaning public areas, such as lobbies, entrance ways, waiting rooms, elevators and restroom facilities.
4. Cleaning office areas, such as administrative, business and admitting offices.
5. Cleaning service areas, such as the laboratory, x-ray, dietary and laundry departments, and the pharmacy.
6. Cleaning walls, ceilings and doors (vertical and overhead areas).
7. Cleaning special areas, such as light fixtures, venetian blinds, and exhaust ducts.

The first step in establishing an active housekeeping cost control program is to determine the *standard of cleanliness* to be maintained in each area or unit of the hospital. For example, in a patient's room it is essential that the housekeeping supervisor know: (1) how often the floor area should be dry-mopped and/or wet-mopped, (2) how often the furniture should be dusted and washed, (3)

how often the walls and doors of the room should be washed, and (4) how often draperies and/or venetian blinds in the room should be washed or changed.

This standard of cleanliness for all areas of the hospital should be determined by the housekeeping supervisor and the supervisor responsible for the work performed in the area being evaluated, and it should be based primarily upon how frequently the area is used and upon the cleanliness required by work performed in the area, in addition to the administrative policies of the hospital.

It is necessary to know how clean an area must be kept before it is possible to develop the procedure used for cleaning the area, the equipment and supplies required, the frequency of performing the cleaning procedure, and the time of day it should be performed.

The standard of cleanliness for each area should be recorded so that a record of it is available for reference when the standard cleaning procedure is developed. The standard of cleanliness for each area also serves as the guide to the housekeeping supervisory staff in evaluating the results achieved from the cleaning assignments.

WORK METHOD

Once the standard of cleanliness for each area throughout the hospital has been determined, the next step in the cost control program is to develop the most effective cleaning procedure to be used in carrying out the cleanliness standard.

It is essential to analyze all of the cleaning procedures presently used. The analysis includes becoming ac-

FLOW PROCESS ANALYSIS

EXHIBIT A

DATE 3/2/54
PAGE 1 of 2

SUMMARY		NO	TIME (Min)	DIST	PRESENT METHOD	PROPOSED METHOD
OPERATIONS	<input type="radio"/>	8			<input checked="" type="checkbox"/>	<input type="checkbox"/>
INSPECTIONS	<input type="checkbox"/>				SUBJECT CHARTED: Cleaning Patient's Room (2 bed room) (218 sq. ft.)	
MOVES	<input type="checkbox"/>	9		64'	DEPT: Housekeeping	
DELAYS	<input type="checkbox"/>				EQUIPMENT, TOOLS, etc. Dust mop, sponge, wet mop, buckets, dolly, mop squeezer	
PERM. STORAGE	<input type="checkbox"/>				ANALYST:	
TEMP. STORAGE	<input type="checkbox"/>	3				
TOTAL		20	15.49	64'		

NO.	DESCRIPTION	ACTIVITY	DIST	TIME
1	Porter transports cleaning equipment to patient's room	□□□□▽	20'	0.58
2	Porter picks up dust mop	□□□□▽		
3	Porter enters room	□□□□▽	4'	
4	Porter dust mops patient's room	□□□□▽		
5	Porter reaches for dustpan	□□□□▽	4'	
6	Porter sweeps soil into dustpan	□□□□▽		
7	Porter transports dustpan to wastebasket	□□□□▽	10'	
8	Porter empties dustpan	□□□□▽		
9	Porter transports dustpan and dust mop to corridor	□□□□▽	4'	
10	Porter places dustpan and dust mop in corridor	□□□□▽		2.75
11	Porter prepares dusting sponge for use	□□□□▽		
12	Porter enters room	□□□□▽	4'	0.20
13	Porter dusts window sills, chairs, doors, dresser, bed and bedside stands	□□□□▽		4.36
14	Porter returns dusting sponge to corridor	□□□□▽	4'	
15	Porter places dusting sponge in pail	□□□□▽		
16	Porter prepares wet mop	□□□□▽		
17	Porter enters patient's room	□□□□▽	4'	
18	Porter wet mops patient's room	□□□□▽	10'	
19	Porter transports mop to pail	□□□□▽		
20	Porter places mop in pail	□□□□▽		7.60
METHODS DEPARTMENT		TOTAL	64'	15.49

quainted with the details of each cleaning procedure and determining the amount of time required to perform the procedure. Many of the cleaning procedures may be classified as repetitive jobs, that is, they are composed of elements that are repeated in the same sequence over and over again each time the cleaning procedure is performed. Thus, the flow process chart may be helpful in analyzing the present cleaning procedures, as it provides a graphical representation of the sequence of all operations, transportations, inspections and storages taking place during the performance of a cleaning assignment.

Exhibit A, shown at left, presents the flow process chart of the present method of cleaning a patient (two-bed) room. The flow process chart of the cleaning procedure portrays the elements of work and often brings to light many previously unknown details of the cleaning operation that may present areas for improving methods.

When the elements of the cleaning procedure are recorded in the sequence of their performance, the time required to perform the cleaning procedure may be obtained by means of a time study. Determining the length of time required to perform the present cleaning procedure will provide factual information to be used for comparative purposes in evaluating proposed cleaning procedures as they are developed.

In developing a standard cleaning procedure, consideration should be given to the possibility of eliminating the job or simplifying it. Substituting a piece of cleaning equipment for an operation previously done by hand, such as using an automatic scrubbing machine where a damp mop is used, is an example of how this might be accomplished. This situation usually results when equipment is purchased for a cleaning procedure prior to determining the actual needs based upon the standard cleanliness requirements.

During the investigative stage of developing a standard cleaning procedure, time study should be used to assist in determining whether the proposed cleaning procedure results in a timesaving. The cleaning procedure

TIME STUDY OPERATION SUMMARY				EXHIBIT B	
				Study No.	1
				Date	3/2/54
				Sheet 1 of	1
Department: Housekeeping					
Operation: Cleaning Patient's Room (2 bed room)					
Unit of study: 1 - 2 bed room (218 sq. ft.)					
Observer:					
No.	Elements	Element Time	Units	Normal Time	
1	Porter transports cleaning equipment to patient's room	0.58	1	0.58	
2	Porter dust mops patient's room, fills and empties dustpan	1.26	2.18	2.75	
3	Porter prepares dusting sponge and enters room	0.20	1	0.20	
4	Porter dusts window sills	0.10	2	0.20	
5	Porter dusts chairs	0.38	2	0.76	
6	Porter dusts doors	0.15	2	0.30	
7	Porter dusts dresser	0.60	1	0.60	
8	Porter dusts beds	0.85	2	1.70	
9	Porter dusts bedside stands	0.40	2	0.80	
10	Porter prepares mop and wet mops patient's room	3.48	2.18	7.60	
Allowances		Normal Time Required, Minutes		15.49	
Process 5.0 % Personal 8.5 %		Allowances 18.5 %		2.86	
Fatigue 5.0 %		Standard Time Required, Minutes		18.35	
		Standard Time Required, Hours		0.305	

Above: Exhibit A shows flow process chart of the present method of cleaning a two-bed room. Below: Exhibit B summarizes a time study resulting from development of cleaning procedures.

requiring the shortest amount of time to perform, however, may not always be the most effective cleaning procedure to use. It is important to consider how it must be performed to achieve the standard of cleanliness required for the area before the final judgment is made.

After the experimentation phase of developing the standard cleaning procedure has been completed, the elements of the proposed cleaning procedure should be recorded in the sequence of their performance and a time study conducted. This detailed record, including the step-by-step method of performing the standard cleaning procedure, the equipment and supplies to be used, and the time required to perform it, represent the facts upon which the cost control program is based. Exhibit B presents a time study operation summary of the proposed standard cleaning procedure for cleaning a patient room (two beds).

Standard time data, that is, the amount of time required to clean a square foot of area, may be obtained by combining the total area cleaned, in square feet, with the time required to perform the standard cleaning procedure. Exhibit C (pp. 70-71) presents a summary of standard time data resulting from the development of standard cleaning procedures.

The standard time data may be used to determine the time required to perform cleaning assignments in other areas throughout the hospital where the standard cleaning procedures are applicable. The application of the standard time data greatly reduces the time required to introduce standard cleaning procedures throughout the hospital.

WORK LOAD REQUIREMENTS

The third step in establishing an active housekeeping cost control program is to determine the work load requirements of the housekeeping department. In determining work load, it is essential to: (1) determine the frequency of performing the standard cleaning procedure; (2) determine the time of day the standard cleaning procedure should be performed, and (3) develop schedules of personnel requirements, for staffing the cleaning assignments in the hospital.

The standard of cleanliness established for each area in the hospital should be used as the basis for establishing the frequency of performing

the cleaning procedure. Certain cleaning assignments should be performed daily, such as cleaning the patient rooms, service and office areas. Others might be performed oftener, such as maintenance of public waiting and restroom areas. Still others might be performed weekly, monthly, quarterly or yearly, such as washing walls and windows and cleaning light fixtures.

The frequency of performing the cleaning assignment is also affected by the use of the areas being considered. If the flow of traffic through the hospital is heavy, the frequency of performing the cleaning assignments in certain areas will be increased. Therefore, the frequency of performing the standard cleaning procedures will depend upon the standard of cleanliness to be maintained and the demands brought forth by how the hospital building is being used.

A majority of the cleaning assignments in many hospitals have been performed during the day shift. At Cleveland Clinic Hospital we have used cleaning personnel on the afternoon shift to clean the service areas of the hospital, such as the laboratory, x-ray, dietary and the administrative areas. This has proved successful as it permits the housekeeping employee to carry out his work assignment without constantly being interrupted by the personnel working the area.

The establishment of an afternoon shift, however, does not permit complete utilization of the employees' time as the service areas of the hospital are usually in operation during a portion of the afternoon shift. Consideration might be given to establishing a night cleaning staff for cleaning the service areas of the hospital. The use of a night staff, when the amount of work will justify a full-time staff, often proves successful, since it permits complete utilization of the cleaning staff without interruption during the entire shift, as all of the service areas of the hospital are vacated during this period.

The laundry, dietary department, main lobby, and service corridors are areas where the use of a night cleaning staff is advantageous. Night cleaning of the laundry and dietary departments permits housekeeping employees to work after these areas have cooled down, thus improving working conditions. We are now cleaning certain of these areas at night, but we have not been able to accomplish this in all the areas.

Improved working conditions usually result in increased productivity. Thus, it is desirable to perform as much of the cleaning work load in the hospital during the afternoon or night shift as possible, provided the work load will justify a full-time staff, as it usually results in improved utilization of cleaning personnel and improved working conditions.

Having determined the standard cleaning procedure, including the tools and supplies to be used, the standard time required to perform the assignment, and the frequency with which the assignment should be performed and the time of day it should be performed, we can now determine the number of the cleaning personnel required for each cleaning category.

Exhibit D (p. 72) presents a sample schedule of personnel requirements for cleaning patient areas located on the third floor of Cleveland Clinic Hospital. Examination of Exhibit D shows that the cleaning requirements for this patient area are broken down into three categories: (1) cleaning patients' rooms, (2) cleaning patients' bathrooms, and (3) cleaning public bathrooms, nursing stations, utility rooms, medication rooms, elevator lobby, telephone booths, conference rooms, and other office and storage areas. A miscellaneous category, including the emptying of wastebaskets and the changing of mop water, is also included.

Total time in hours required to clean the third floor patient area varies from a total of 32.129 hours on Monday and Friday to a total of 23.448 hours on Tuesday, Wednesday, Thursday, Saturday and Sunday. This total time required is based upon the cleaning requirements for each of these days. These cleaning requirements were in turn determined after we established a standard of cleanliness for each of these areas.

Project work is also included in the over-all weekly schedule. It includes the washing of doors and wastebaskets. A total of 10.685 hours is provided on Monday and Friday for the performance of project cleaning work.

The table at the bottom of Exhibit D presents the total number of cleaning maids required per day to maintain the patient area on the third floor. The total number of cleaning maids required per week, based on 40 hours per week, is also included. In this instance, 4.65 cleaning maids, or 5 cleaning maids, are required to

meet the standard of cleanliness established for this area.

After standard production data regarding the cleaning procedures to be used and the number of cleaning personnel required to clean the various areas of the hospital have been developed, it is desirable to transform this information so that it can be readily used by the employee assigned to carry out the assignment. The housekeeping supervisor plays an important rôle in carrying forth this phase of the cost control program.

WORKING SUPERVISION

The housekeeping supervisor is the key to the success of a cost control program. The supervisor serves a threefold purpose in the development and application of a cost control program: (1) She participates in the development of the standard cleaning procedures; (2) she is responsible for training the employee in the use of the standard cleaning procedures, and (3) she is responsible for obtaining results from the program, through direct on-the-job supervision.

Direct supervision is particularly important in the operation of the housekeeping department as many of the department employees are located throughout the hospital and are usually left to themselves to complete their assignment. A cost control program will not substitute for direct supervision. The mechanics of supervision, however, are greatly reduced when it is possible, through the application of the cost control program, to provide the employees with an all-day assignment showing the jobs to be done, the methods to be used, the equipment and supplies required, and the time required to perform the work.

Supervisors must insist on quality in the work produced. Not only are they concerned with seeing that the cleaning procedure is completed on schedule but also that the quality of the work meets the standard of cleanliness established for the area.

The housekeeping supervisors, in most instances, are responsible for the training of all housekeeping personnel. The training of the employee consists of both formal and on-the-job instruction. The initial step in the formal training program, after the selection of specific employees for the assignments outlined by the standard cleaning procedures, consists of presenting each employee with the details of the assignments. This may be accom-

EXHIBIT C—STANDARD TIME DATA HOUSEKEEPING DEPARTMENT

Area	Operation	Minutes per Unit	Work Unit	
PATIENTS' ROOMS	1. Dust mop patient's room, fill and empty dustpan			
	a. Private room	1.00	100 sq. ft.	
	b. 2 bed room	1.26	100 sq. ft.	
	c. Ward	1.00	100 sq. ft.	
	2. Damp dust with sponge			
	a. Chair	0.38	1 each	
	b. Dresser	0.60	1 each	
	c. Bedside stand	0.40	1 each	
	d. Bed	0.85	1 each	
	e. Window sill	0.10	1 each	
	f. Screen	0.45	1 each	
	3. Damp mop patient's room			
		M&F	TW&Th&S	
	a. Private room	2.75	2.75	100 sq. ft.
	b. 2 bed room	4.50	3.48	100 sq. ft.
	c. 4 bed ward	4.18	3.42	100 sq. ft.
	d. 6 bed ward	4.15	3.12	100 sq. ft.
	e. 12 bed ward	2.85	2.85	100 sq. ft.
4. Transport equipment between patients' rooms	0.58			
PATIENT AND PUBLIC BATHROOMS	1. Clean wash basin and mirror	2.92	1 each	
	2. Clean bath tub	3.42	1 each	
	3. Clean shower stall and walls	5.00	1 each	
	4. Clean bedpan rack and interior of storage cabinet including mirror	4.13	1 each	
	5. Clean commode and seat	2.34	1 each	
	6. Clean commode brush bowl	0.75	1 each	
	7. Spot bathroom walls	1.49	1 each	
	8. Clean urinal	2.12	1 each	
	9. Transport equipment between patients' bathrooms	0.27		
MISCELLANEOUS: NURSING CORRIDOR	1. Change mop water (2 buckets)	8.32	1 change	
	2. Collect wastepaper on nursing division (a.m.)	0.46	1 basket	
	3. Collect wastepaper on nursing division (p.m.)	0.62	1 basket	
	4. Clean drinking fountain	1.25	1 each	
	5. Dust wheel chairs	0.50	1 each	
	6. Dust lobby desk and contents	2.37	1 each	
	7. Dust lobby furniture and window sills	8.79	1 lobby	
	8. Dust venetian blinds (lobby size)	6.58	1 each	
	9. Change roller towel	2.97	1 each	
	10. Wash wastebaskets (pick up, wash, dry and deliver)	4.05	1 each	
	11. Wash door to patient's room (wash, dry, including mechanical)	7.39	1 each	
	12. Clean pediatric stainless steel sink	2.90	1 each	
CORRIDOR AND ROOM FLOOR MAINTENANCE	1. Apply stripping solution to floor section for removing existing wax from floor with mop	0.0306	1 sq. ft.	
	2. Scrub floor section containing stripping solution with 19 inch scrubbing machine	0.044	1 sq. ft.	
	3. Remove stripping solution from floor section with mop	0.045	1 sq. ft.	
	4. Wet mop stripped floor section with clear water	0.053	1 sq. ft.	

Exhibit C. On this and the next page is shown a summary of standard time data resulting from the development of standard cleaning procedures. These data may be used to determine the time required to perform cleaning assignments in other areas where they are applicable.

EXHIBIT C—STANDARD TIME DATA HOUSEKEEPING DEPARTMENT

(Continued From Page 70)

Area	Operation	Minutes per Unit	Work Unit
CORRIDOR AND ROOM FLOOR MAINTENANCE	5. Wait for floor to dry after wet mopping	0.0169	1 sq. ft.
	6. Apply one thin coat of finish to floor section with 24 oz. mop	0.025	1 sq. ft.
	7. Apply additional coats of finish to floor section with 24 oz. mop	0.018	1 sq. ft.
	8. Dust mop hospital corridor floor, using 48 inch dust mop	0.0017	1 sq. ft.
	9. Damp mop corridor floor	0.014	1 sq. ft.
	10. Damp mop corridor floor, two times	0.027	1 sq. ft.
	11. Wait for floor to dry after damp mopping	0.007	1 sq. ft.
	12. Buff floor using 19 inch scrubbing machine	0.035	1 sq. ft.
	13. Dust mop utility room floor	0.010	1 sq. ft.
	14. Damp mop utility room floor	0.037	1 sq. ft.
	15. Sweep kitchen floor area using 36 inch push broom	0.0025	1 sq. ft.
	16. Transport mop equipment	0.012	1 sq. ft.
	17. Transport scrubbing machine	0.010	1 sq. ft.
STAIRWAYS AND LANDINGS	1. Dust mop steps—49" long by 11" deep by 8" high, using 12" dust mop	0.0704	1 step
	2. Dust mop floor landing	0.860	1 landing
	3. Dust mop auxiliary floor landing	0.380	1 landing
	4. Dust portable fire extinguisher, permanent fire hose and wall cabinet	1.40	1 unit
	5. Wet mop stairs—49" long by 11" deep by 8" high	0.527	1 step
	6. Wet mop stairs—42" long by 10" deep by 8" high	0.411	1 step
	7. Wet mop floor landing	4.18	1 landing
	8. Wet mop auxiliary floor landing	3.65	1 landing
	9. Prepare 1 bucket of water and add the required amount of detergent	2.00	1 bucket
	10. Change 1 bucket of water and add the regular amount of detergent	2.60	1 bucket
MECHANICAL SCRUBBING OPERATION*	1. Main kitchen floor area	0.675	100 sq. ft.
	2. Storeroom	0.353	100 sq. ft.
	3. Hospital 1st floor	0.555	100 sq. ft.
	4. Hospital 2d floor	0.687	100 sq. ft.
	5. Hospital 7th floor	0.536	100 sq. ft.
	6. Hospital floor lobbies (2d fl. through 7th fl.)	0.488	100 sq. ft.
	7. Hospital main lobby (double scrub)	1.300	100 sq. ft.
	8. Empty soiled tank, rinse with hose and clean exterior of machine	15.50	
	9. Fill clean tank with water and add required detergent	3.40	
	10. Connect electrically	1.85	1
	11. Disconnect electrically	1.15	1
	12. Transport finnell machine	1.20	100 ft.
	13. Empty soiled tank with bucket, refill with water and add required detergent	4.25	1

*Floor scrubbing machine applies the cleaning material to floor, scrubs and picks up the water in one operation.

plished by the use of instruction cards which have been developed for each phase of work included in their assignment.

The instruction cards, prepared from the sequential breakdown of each standard cleaning procedure as discussed previously, contain the following information:

Operation or procedure

Area where operation is to be performed

Step-by-step detailed breakdown of the procedure

Precautions concerning the operation

Equipment and supplies needed

Time required to perform the procedure

The instructions are written in simple language and in detail so the employe responsible for performing the procedure will have little doubt regarding:

What is to be done

Where it is to be done

What equipment to use

How long it should take to do it

After the employe is formally instructed in the details of the procedure, on-the-job training is provided by the supervisor to supplement the formal training. Instruction cards may be retained by the employe as a permanent record of the required work assigned to him.

WORK SUPPLIES

The fifth step of the cost control program concerns itself with work supplies. The selection of the proper equipment and supplies to be used in performing a cleaning procedure is most important if a hospital is to obtain effective utilization of its cleaning personnel and equipment. The use of a supply item not suited for the particular cleaning assignment may increase the amount of work required, thus raising the cost of cleaning that particular area.

Supervisors of the housekeeping department must be constantly on the alert to uncover new cleaning materials and equipment that will best serve their cleaning needs. Study programs should be conducted periodically to determine whether the standard cleaning procedure should be changed, whether a new piece of equipment should be adopted, or whether a new cleaning product should be substituted for the present product.

Evaluation of new housekeeping supplies and equipment is greatly

**EXHIBIT D—HOUSEKEEPING DEPARTMENT SCHEDULE OF
PERSONNEL REQUIREMENTS—3d FLOOR**

Operation	Mon. & Fri.		Tues., Wed., Thurs., Sat. & Sun.		
	Units	Unit Standard	Total Time	Unit Standard	Total Time
		Time (Hrs.)	(Hrs.)	Time (Hrs.)	(Hrs.)
1. CLEANING PATIENT ROOMS					
a. Private rooms (existing bldg.)	6	0.230	1.380	0.230	1.380
(new bldg.)	2	0.268	0.536	0.204	0.408
b. Semi-pri. rooms (existing bldg.)	10	0.322	3.220	2.70	2.700
(new bldg.)	19	0.340	6.460	0.238	4.520
c. Three-bed rooms	2	0.395	0.790	0.317	0.634
d. Four-bed rooms	4	0.488	1.952	0.371	1.484
e. Six-bed rooms	1	0.567	0.567	0.450	0.450
f. 12 bed rooms	1	0.955	0.955	0.955	0.955
			15.860		12.531
2. CLEANING PATIENT BATHROOMS					
a. Basin, commode and tub	6	0.274	1.640	0.178	1.067
b. Basin and commode	37	0.214	7.920	0.119	4.400
c. Basin	3	0.049	0.098	0.049	0.098
			9.658		5.565
3. AUXILIARY AREAS					
a. Patient baths, tubs	5	0.097	0.485	0.097	0.485
b. Patient showers	4	0.162	0.648	0.162	0.648
c. Personnel bathrooms	3	0.121	0.363	0.121	0.363
d. Public bathrooms	1	0.121	0.121	0.121	0.121
e. Bedpan room	1	0.223	0.223	0.223	0.223
f. Janitor's closet	2	0.075	0.150	0.075	0.150
g. Nursing stations	3	0.030	0.090	0.030	0.090
h. Utility rooms	2	0.051	0.102	0.051	0.102
i. Medication rooms	3	0.030	0.090	0.030	0.090
j. Elevator lobby (west)	1	0.058	0.058	0.058	0.058
k. Telephones (lobby)	1	0.050	0.050	0.050	0.050
l. Conference room	1	0.280	0.280	0.110	0.110
m. Linen room	1	0.075	0.075	0.075	0.075
n. Supervisor's office	1	0.180	0.180	0.070	0.070
o. Wheel chairs	8	0.007	0.056	0.007	0.056
p. Water coolers	3	0.021	0.063	0.021	0.021
			3.034		2.712
MISCELLANEOUS					
a. Emptying wastebaskets	2	0.840	1.680	0.840	1.680
b. Change mop water	10	0.138	1.380	0.138	0.690
c. Clean hospital floor lobby	1	0.517	0.517	0.270	0.270
			3.577		2.640
TOTAL TIME			32.129		23.448
PROJECT WORK					
a. Washing doors and mechanisms 62/wk.		0.123	7.630		
b. Wash wastebaskets 45/wk.		0.068	3.055		
			10.685*		
TOTAL TIME INCL. PROJECT WORK			32.129		27.008

The personnel requirement for the 3d floor of the hospital is as follows:

Floor	Maids required per day							Total maids required/week (Based on 40 hours/week)
	Sun.	Mon.	Tue.	Wed.	Thurs.	Fri.	Sat.	
3d	2	4	3.4	3.4	3.4	4	3	4.65 or 5

*This work to be completed on Tuesday, Wednesday and Thursday of each week on an equal basis per week, or 3.56 hours per day.

Exhibit D. Sample schedule of personnel requirements for cleaning patient areas located on the third floor of Cleveland Clinic Hospital. Cleaning is broken down into (1) patients' rooms; (2) patients' bathrooms; (3) public areas.

simplified once an active cost control program is in operation. When the factual information regarding the time required to perform a cleaning procedure and the frequency of performing the procedure are readily available, an analysis of new equipment or supplies may be made in the minimum amount of time to determine whether it should be adopted. This judgment may be based upon fact rather than upon opinion.

A procedure including the ordering and stocking of cleaning supplies should be developed. Consumption data regarding the use of supplies should be determined, based upon operating experience and quantities established by the standard cleaning procedures. The data will serve as a guide for determining the proper quantity of each cleaning supply that should be carried in stock, along with the reorder level for each supply.

Consumption of cleaning materials may be based on square feet. The housekeeping supervisor can then readily detect excessive usage of any item. Detection of an abnormally high rate of usage may serve as a clue to the fact that a standard cleaning procedure is not being followed.

WORK INTEREST

The last phase to be considered in the establishment of a cost control program is work interest. The work interest among employees performing cleaning assignments improves when the method of performing a cleaning assignment has been standardized, the employee has received instruction and training in the work procedure, the employee has received the required equipment and supplies to carry out the cleaning assignment, and ample storage space has been provided for the employee to store his equipment and supplies.

Work interest also may be increased by establishing an incentive pay system based on the production standards developed in the cost control program. We have not done this at our hospital. The incentive pay system provides a means of compensating an employee for the work he performs above that required by the standard cleaning procedure. Though most of us do not use incentive pay methods, the production standards can be used to give merit pay raises to those employees who earn them and also to show those who do not deserve a raise exactly why they do not.

Why Can't People Be Like Machines?

Machines are beautiful and shiny and when they don't do their jobs right a little tinkering will set them straight. But people! They're careless and rude and independent—and they talk back. You can't straighten them out by turning dials. No wonder sensible administrators prefer machinery

RUSSELL DRUMM

DAVID JONES, A.B., M.S., and A.C.H.A., hospital administrator, was hurt, thwarted, puzzled and chagrined. On his desk before him lay four letters and, though each looked different, in essence they were the same. They were all letters of patient complaint. He frowned at them, leaned wearily back into his well padded swivel chair, and contemplated the fireproof and sound-absorbent ceiling of his office. Mr. Jones loved this office. It was new, quiet and tidy and had been built to his exacting specifications. It could hardly have been improved. A button close to his hand could summon a secretary to transcribe his every word. Conditioned air was supplied for his comfort. The pictures, draperies and carpet all reflected his own good taste. There was even his personal and private lavatory adjoining, all tile and chrome. Yes, at times he was loathe to wander from this ivory tower. For a forgetful moment he smiled.

But these four letters—they were a blotch, a stain, and an abomination there before him on the polished walnut, with their allegations of error and sloth within this new and elegant structure. But, he supposed hopefully, there always would be cranks, snarling and grumbling about imaginary faults in any institution—crackpots and malcontents who could never be satisfied.

These particular criticisms, however, had a curious odor of legitimacy about them that made Administrator Jones a trifle ill. Perhaps he should investi-

Mr. Drumm is administrator, Nyack Hospital, Nyack, N.Y.

gate for himself this time and prove once and for all that these unsolicited slurs were without foundation. But on second thought, no. That would entail a lot of palaver with nurses and cashiers and maids and dietitians and such people as that. Probably this was the time to sit back and dictate a directive. He'd done it before. Why not again? Maybe it was time for a department head meeting. In the crush of other affairs he hadn't called one in months.

IT WAS THE LATEST AND BEST

Across the flower-lined patio just outside his picture window of heat absorbent glass, the hospital director could see the clean, functional lines of the west wing. He envisioned the long, tiled corridors, the gleaming metal cabinets, and even the sturdy little wall safes that housed narcotics. The latest and best medicines that science had evolved stood vialled in orderly rows. The majestic autoclaves were metal monuments that glistened in sterile grandeur. Those conductive terrazzo floors in the O.R.'s had been installed at a nerve-twisting cost, not to mention the endless tray conveyors and automatic bedpan washers. His mind boggled at the wondrous amalgamation of science, art, money and migraine that had made possible this medical mansion.

And yet, former patients like these letter writers (What were their names again?—Forster, Fanfanari, Bielski and Cohn) were not satisfied. They had complaints.

He lighted a cigar and gazed thoughtfully through the smoke for a time and wondered. Then, with obvious distaste, he reopened one of the letters and read the penciled page.

"Dear Mr. Superintendent,

I just got out of your hospital and I'm feeling fine except for one thing, my teeth. Not because they hurt me, because they are lost. I had a upper plate when I went in and they got lost when I went to get my operation. I been eating soup now ever since and

(The nurse forgot to safeguard old Mr. Forster's dentures. Later she realized this, but then it was too late. Anyway, there never had been any set procedure for this, at least she had never heard of any. Besides at 9:30 a.m., when the patient was being wheeled from his room on the stretcher, was exactly when Joe Fenton, the pediatric resident, was having coffee. The nurse knew that. Even as she pushed the litter, Dr. Joe was probably having coffee with that lab technician who had dyed her hair. What could Joe see in her?)

The nurse pushed the litter to the O.R. As she remembered Dr. Joe, she forgot Mr. Forster's teeth. Later, the O.R. nurse removed the patient's dentures, wadded them in gauze for protection, and placed them on a near-by Mayo. They were never seen again. Wads of gauze are quickly thrown out when the surgery is done.

Old Mr. Forster had a devil of a time with food during the remainder of his hospital stay. He got real mad,

too. But eventually he recovered—his health, that is, not his teeth.)

Administrator Jones swore softly but with feeling and reached for the second letter. It was neatly penned, and came directly to the point.

"Dear Mr. Jones:

As a member of the hospital's auxiliary and long active in its affairs, I have frequently bragged about our institution to all who would listen. Now, after a short hospital stay, however, I'll not be so willing to brag. During my recent hospitalization I was repeatedly served cold food, meal after meal. My complaints did no good. I know there is probably some plausible reason for this, but nevertheless—"

(Mrs. Fanfanari sat up against her pillow and ruefully examined the dinner tray in her lap. The food looked—maybe clammy was the right word. She tasted. The mashed potatoes were room temperature, though the gravy had not quite congealed. The peas—chilly, but soft. Oh, they had been cooked all right, at some former time, and at least there was no danger of being scalded by the coffee. No danger at all. The patient ate very little.

The potatoes, peas, cutlet and coffee had been piping hot when placed upon the belt-conveyed tray. It all had then been popped into the insulated stainless steel food cart and started toward the patient's floor; hot, tasty, inviting. It was when leaving the elevator that Rosalie, the cart-pusher, saw Millie, the tray-server, and had to stop and tell her about the trouble she was having with her husband, Frank. She had worked her fingers to the bone to give that man a good home. Yet, he stayed down at the V.F.W. most every night in spite of their having a new TV set at home. He seemed cool lately—

The potatoes, peas and cutlet seemed cool, too, in spite of the automatic tray belt and the stainless steel cart.)

It was frustrating and made a man feel helpless, insufficient. Administrator Jones nostalgically recalled a pick and shovel job he'd had one summer vacation. Then, in an attempt at reckless abandon, he flipped open the third envelope. At the top was the letterhead of a well known local law firm. The letter had been typed.

"Dear Sir:

It was bad enough to have to pay a whopping hospital bill when I couldn't really afford it, but when your cashier treated me like a worthless bum, I got mad. In my business—"

(In the business office the red nails were poised above the stilled keys. The girls were listening, tuned in on the angry shouts of Mr. Bielski, who had stopped on his way out of the hospital to settle his account. Kathleen, the cashier, who feared no man, had, for the amusement of all and sundry, decided once again to show her superiority over a patient. The other girls considered Kitty a real comic when she decided to work a customer over. "Why can't you understand your bill?" she was asking. "You can read, can't you? After all, I don't get paid enough to explain it, I just get paid to take your money." Her ears were cocked for the giggled approval of her audience as she watched the patient turn a satisfactory red color. The girls really enjoyed it, too. Eventually Mr. Bielski paid up. When he threatened to report the cashier, they could contain it no longer; they howled. Honestly, that Kitty was a card.)

WHY MR. JONES WAS TIRED

Jones was tired. It was still early in the day and yet he felt as though he'd been beaten with a club. There was another letter to go, and he should read it, but this was too much. He had only courage enough to give it a glance and catch the middle part of the letter, an excerpt "... dust on everything, dirty towels, and the maids gossiping and sneaking a smoke on the fire tower." This was the crowning indignity. Jones growled ominously.

(The executive housekeeper had a symptom. It was not constant, merely periodic, but it was a handicap when present. The first manifestation was a dry tickle in the throat that water would not disperse. Next came that fidgety feeling, a nervousness that wrecked her knitting and meant kicks and other troubles for her apartment partner, the cat. There was, fortunately, a specific, a medication to alleviate her discomfort—whiskey and warm water, one large tablespoonful every 15 minutes, and continuing larger doses until relief was noted. It worked every time, though admittedly there was certain side effects after the treatment, which sometimes hung over for a day or two, during which time she rested. It was during the most recent convalescence that she felt unable to inspect many of the rooms. It was also during this latest siege that the maid who was to have done Mrs. Cohen's room had a couple of carefree days. Got her feet rested up too. Peaceful.)

David Jones, hospital administrator, crumpled the last letter and threw it forcefully to the floor. There was no doubt about it, these four letters indicated reason for great concern. These people couldn't all be wrong. Something had to be done. Four complaints, and from the same departments as before. He'd start with the department heads right now and get to the bottom. It was just too bad that there weren't some stainless steel machines to save people's dentures, to ensure hot food, to take patients' money, to dust the rooms. If they did wrong, one could just turn a dial or something and make it right.

HE'D LOOK INTO THIS

But enough time had been lost already. He'd see the people responsible, face them with these damning accusations, look into these allegations himself, and get things straightened out. Yes, it would be hard to do, all right. People were independent, unpredictable and always seemed to have an excuse. Problems by themselves were easily solved, but the people involved—they were quite another matter. The time was ripe. He rose briskly from his chair.

David Jones, an angry and determined administrator, started toward the kitchen. He would first confront the chief dietitian with the letter about the cold food. No sense to it. About time she got her people in line, or else, and he'd tell her so in no uncertain terms. She had enough good equipment. There was just no reason for the food to be anything but delicious and hot.

It was just as Mr. Jones left the elevator, heading toward the dietitian's office, that he again noted the new and smoothly running tray conveyor in motion. What a beauty, all synchronized and its endless belt sliding softly down its track. Electrical all the way through. By George, there was something that did the job right every time, and no kidding about that. He stopped and watched the machine for a while. Then, because he had a real hankering for it, he tried the switch, stopping it and starting it a few times. Here was something a man could depend upon. And over there was the automatic dishwasher. That was quite a gadget, too. Mr. Jones left the tray conveyor and headed toward the steamy area around the dishwasher. He'd never operated this one. Maybe he'd give it a try.

ABOUT PEOPLE

Administrators

Sheridan C. Snider, assistant director of East Orange General Hospital, East Orange, N.J., has been named director of the hospital, succeeding the late **Edgar C. Hayhow**. Mr. Snider, who has been associated with East Orange General since 1954, currently is president of The Oranges and Maplewood (N.J.) Hospital Council. Before going to East Orange, he was administrative director of the Empire Medical Group in Brook-



Sheridan C. Snider



Forrest A. Brower

lyn, N.Y., a group health insurance plan. At the same time it was announced that **Forrest A. Brower**, administrative assistant, will succeed Mr. Snider as assistant director of East Orange General. Mr. Brower is a graduate of Columbia University's school of public health and administrative medicine and served his administrative residency at Harper Hospital, Detroit.

T. Truxton Hare Jr. has been appointed president of Pennsylvania Hospital, Philadelphia, succeeding V. Adm. **Robert M. Griffin**, U.S.N. (Ret.), who recently retired from active participation in the affairs of the hospital. Mr. Hare assumes responsibility for supervision and coordination of the hospital's Department for the Sick and Injured, Department for Mental and Nervous Diseases, and the Institute of the Pennsylvania Hospital. Prior to his appointment Mr. Hare served 10 years with the Central Intelligence Agency of the government.

Donald E. Gilbert, assistant director of Genesee Hospital, Rochester, N.Y., has been named administrator of Brockton Hospital, Brockton, Mass., succeeding **Wesley D. Sprague**, whose appointment as associate director of New England Deaconess Hospital, Boston, was announced in the October issue of *The Modern Hospital*.

Albert W. Jones, assistant administrator of Ball Memorial Hospital, Muncie, Ind., has become administrator of Bethesda Hospital, Zanesville, Ohio.

Edward W. Gilgan, director of Hurley Hospital, Flint, Mich., has been named full-time adviser for the Sisters of the Third Order of St. Francis, who own and operate 12 hospitals in Illinois, Iowa, Michigan and South Carolina. The appointment is effective December 1. Prior to assuming his present post in Flint in April 1954, Mr. Gilgan was superintendent of Ryburn Memorial Hospital, Ottawa, Ill.



Edward W. Gilgan

William A. Clermont, administrative assistant at Waterbury Hospital, Waterbury, Conn., has been appointed administrator of Alice Hyde Memorial Hospital, Malone, N.Y. He is a graduate of the hospital administration course at Yale University.

Fred K. Fish, director of Lutheran Hospital, Brooklyn, N.Y., has been named executive director of New York Polyclinic Medical School and Hospital, New York.

Roy C. House has been named administrator of Wesley Hospital and Nurse Training School, Wichita, Kan., succeeding **Rev. Armour H. Evans**, whose appointment as administrator of Methodist Hospital, Pikeville, Ky., was reported in the October issue of *The Modern Hospital*. Mr. House has been administrator of Marion General Hospital, Marion, Ind., for four years. He is a graduate of Northwestern University's hospital administration course and a fellow of the American College of Hospital Administrators.

William C. Lightburn has succeeded **Charles M. Edwards** as assistant administrator of Lincoln General Hospital, Lincoln, Neb. Mr. Edwards has accepted a position as administrator of Sedalia Memorial Hospital, Sedalia, Mo. Mr. Lightburn recently completed his residency at Asbury Methodist Hospital, Minneapolis.

Lois J. Naughten, R.N., has been appointed superintendent of Silverton General Hospital, Silverton, Ore. Miss Naughten, a graduate of the University of Oregon School of Nursing, has been associated with Oregon State Hospital, Salem.

L. S. Hartford, assistant administrator of University of Texas Hospitals, Galveston, has been appointed administrator of Newton Memorial Hospital, Newton, N.J. Mr. Hartford also has served as administrator of Henry County Memorial Hospital, Mount Pleasant, Iowa. He is a graduate of Columbia University's hospital administration course.

Stephen L. Barrett has been named assistant to the administrator at Middlesex Memorial Hospital, Middletown, Conn., succeeding **Ward E. Edwards**,



Stephen L. Barrett

whose appointment as assistant administrator of Lutheran Deaconess Hospital, Minneapolis, was reported in the October issue of *The Modern Hospital*. Mr. Barrett is a graduate of the University of Minnesota's hospital administration program.

Steve F. McCrimmon has resigned as administrative director of Doctors' Hospital, Coral Gables, Fla., to become administrative director of Baptist Hospitals of Miami, Fla. Mr. McCrimmon will be installed as president of the Florida Hospital Association on November 21.

James McKelvey Jr. was recently appointed administrator of West Orange Memorial Hospital, Winter Garden, Fla. Previously he was associated with Blue Cross-Blue Shield of Florida, Inc.

Clara M. Steiner has resigned as business administrator of Murphy Medical Center, Warsaw, Ind. Mrs. Steiner served as administrator of McDonald Hospital in Warsaw until the two institutions merged recently. **June Schick** will succeed Mrs. Steiner at Murphy Medical Center. Before going to Warsaw, Mrs. Steiner was administrator of Wells County Hospital, Bluffton, Ind.

Garnett L. Radin, R.N., has been appointed assistant director of Shriners Hospital for Crippled Children, Lexington, Ky. Mrs. Radin recently completed her administrative residency at Jackson Memorial Hospital, Miami, Fla. She is a graduate of Northwestern University's program in hospital administration.

(Continued on Page 138)

Staphylococcal Infections Transmitted by Hospital Personnel, Investigators Report

ATLANTIC CITY, N.J. — Infected personnel play a major rôle in transmission of staphylococci in hospitals, a group of investigators from Temple University Hospital and School of Medicine, Philadelphia, reported at the 43d annual Clinical Congress of the American College of Surgeons here last month.

However, the group acknowledged, most information about the spread of these infections is still speculative.

"We still do not really know how a staphylococcus is transmitted to a patient, what rôle the healthy nasal carrier plays in dissemination, or whether an organism in an air-borne droplet has the same virulence as an organism in a draining abscess," said Dr. Kenneth M. Schreck, reporting for the group.

323 CASES REPORTED

In the year-long Temple Hospital study, 323 patients developed staphylococcal infections in the hospital, the report said. Of this number, 172 had postoperative infections, and 58, cutaneous infections not related to surgery. Forty-five newborn infants had either cutaneous infections or breast abscesses; and 48 mothers had breast abscesses following delivery.

Examination of nasal cultures showed 265 of 640 hospital employees were staphylococcus carriers, but only 11 of these were carrying the type of organism causing most of the infections.

Nevertheless, hospital personnel had an "unusual number" of cutaneous infections, the investigators found.

"Hospital personnel frequently treat themselves and remain on duty; therefore, these infections have to be sought out," the report said. "During the year, 99 of our personnel had a total of 137 known staphylococcal infections, 65 per cent of which were on the upper extremity or face, the areas most accessible to the patient."

Following completion of the study, the hospital was successful in bringing about a reduction in the incidence of infection to an "acceptable" level, it was reported, by use of these measures:

1. Reemphasis on aseptic surgical technic; scrub technic was changed to a 10 minute scrub with soap and water followed by a 70 per cent alcohol dip. Patient's skin at the operative site was

prepared with soap and water scrub followed by ether rinse, followed by 70 per cent alcohol rinse.

2. Penicillin solution was instilled in surgical wounds at the time of closure.

3. Patients with staphylococcal infections were isolated as far as possible; their linen was handled as contaminated linen. Infections were treated conservatively with incision and drainage. Antibiotics were reserved for those who were extremely ill; use of prophylactic antibiotics in the post-operative period was discouraged.

4. Personnel with active infection were removed from duty, treated and not returned to duty until all drainage had stopped.

5. Measures were instituted to improve general housekeeping procedures throughout the hospital.

Healthy nasal carriers among hospital personnel were not removed from duty, the report said.

Injury is no respecter of the carefully drawn lines between the various medical and surgical specialties, and accident victims suffer because there is no such thing as a specialist in trauma, and coordination among the specialties has been inadequate, Dr. Harrison L. McLaughlin, professor of orthopedic surgery at Columbia University's College of Physicians and Surgeons, New York City, told the congress.

To improve the care of injured patients, Dr. McLaughlin recommended:

1. Better coordination of the teaching of trauma in medical schools. The subject is now divided among several divisions in the department of surgery, it was pointed out.

2. Elimination of "small cold wars" between surgical specialties in connection with care of various kinds of trauma.

3. Broad postgraduate training for surgeons in all aspects of trauma.

4. Improved training of general surgeons and all surgical specialists in fundamentals of trauma.

5. Establishment of separate trauma services in hospitals, with support by members of the staff in all surgical departments.

Pointing out that the results of trauma continue to fill more civilian surgical beds than any other condition, excepting cancer, Dr. McLaughlin said that, nevertheless, "standards for treat-

ment of trauma remain at a level lower than in any other branch of surgery."

Coordination of trauma service must be carried into hospital staff organization, Dr. McLaughlin stated. "The era of an emergency ward or receiving room, staffed by a junior resident, is drawing to a close," he said. "It would be difficult to overestimate the value to any hospital of a service for the care of trauma, backed by a competent staff and supervised by mature residents from every surgical department. Such services as presently exist have proved their worth in values which are obvious, and they will serve admirably as models for the future."

TELL PATIENTS WHAT IT COSTS

Dr. William L. Estes Jr. of Bethlehem, Pa., newly elected president of the College, said in an address that surgical patients should know how much their operations are going to cost, and a frank discussion of costs, insurance and other financial details with the patient or a member of his family is the surgeon's responsibility.

Better distribution of surgical skills, as well as improvement of surgical knowledge and technics, is the obligation of the profession, Dr. Estes said. A great opportunity for young surgeons exists in "well organized and splendidly equipped community hospitals," he pointed out.

"We must recognize the need for bringing to outlying and rural segments of the country the advances in surgical science as they are produced," he added, "and deliberately encourage not simply the creation of surgical competency, but an increasingly better distribution of this essential commodity."

Widespread establishment of rural clinics for group practice has helped promote opportunities for well trained surgeons, Dr. Estes reported. "The trend of young surgeons toward suburban sections of our centers of population could well be duplicated in less densely populated areas of the country," he said.

To assist in this movement, he explained, the College was listing areas or communities throughout the country that have been recorded as desiring a well trained surgeon or surgical specialist, and making this information available to qualified surgeons just beginning practice or wishing to change location.

PROTOTYPE STUDY:

PROPRIETARY HOSPITALS

**Beginning a new series of "prototype studies"
of proprietary short-term general hospitals with
up-to-date information on principal departments**

LOUIS BLOCK, Dr. P.H.

*Chief, Research Grants Branch
Division of Hospital and Medical Facilities
Public Health Service, Washington, D.C.*

THE status of proprietary short-term general hospitals in this country has long been considered as one of relatively diminishing importance. Despite this, today they still represent 15 per cent of all hospitals in the United States and 20 per cent of all general short-term hospitals. However, the proprietary hospital represents only 2.3 per cent of all beds and 6.5 per cent of all beds in general short-term hospitals. There are more than 1000 proprietary short-term general hospitals in the United States and its territories.

This factual summary of the status of this particular control group of hospitals presents information relating to its facilities, their use, finances and personnel. In addition, facts concerning their distribution by type of service and other specific relationships are shown.

It was recognized that there was a need for the development of prototype studies of this hospital group in order to provide a guide for comparison and self-evaluation similar to those prepared for the nonprofit short-term general hospital which have appeared in *The MODERN HOSPITAL*. In order to meet the requirements for such an evaluation tool, prototype studies have been developed for the proprietary general hospitals of 15, 25, 50, 75, 100, 125 and 150 beds. The prototype study of the 25 bed hospital begins on page 78. Studies of hospitals of other sizes will be published in succeeding issues.

In addition, comparisons of the nonprofit and proprietary hospital studies reveal areas of similarity and areas of differences in the provision and utilization of services. Such a comparison for the 25 bed hospital appears on pages 80 and 81.

OF ALL THE HOSPITALS in the United States, the proprietary short-term general hospitals represent the following percentages of the total in the listed categories:

	Per Cent of Hospitals		Per Cent of Hospitals
Total hospitals	14.7	All births	5.9
Number of beds	2.3	Total assets	1.2
Daily adult census	1.6	Plant assets	1.2
All admissions	6.9	Total expenses	3.1
All bassinets	7.9	Payroll expenses	2.5
Daily newborn census	4.5	Total full-time personnel	3.1

OF ALL THE SHORT-TERM GENERAL HOSPITALS in the United States, the proprietary short-term general hospitals represent the following percentages of the total in the listed categories:

	Per Cent of Hospitals		Per Cent of Hospitals
Total hospitals	19.5	Total assets	2.1
Number of beds	6.5	Plant assets	2.3
Daily adult census	5.5	Total expenses	5.1
Admissions	7.6	Payroll expenses	4.3
Bassinets	8.3	Full-time personnel	4.9
Daily newborn census	4.8		
Births	6.2		

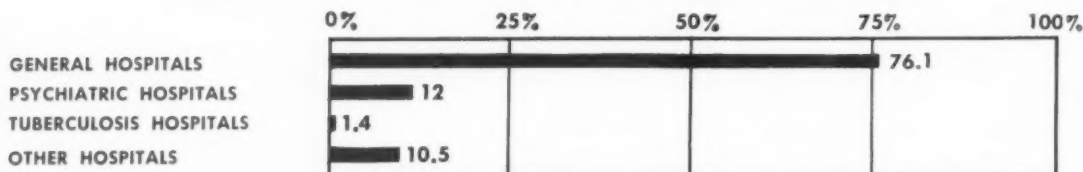
Of these proprietary short-term general hospitals, 44.6 per cent are under 25 beds in size, while 81.3 per cent are under 50 beds in size.

The proprietary short-term general hospitals in the United States account for the following percentages of all hospitals offering the services listed:

	Per Cent of Hospitals		Per Cent of Hospitals
Basal metabolism	14.1	Pharmacy	7.1
Blood banks	9.8	Physical therapy department	8.5
Central sterile supply rooms	11.8	Postoperative recovery room	5.9
Clinical laboratory	13.5	Premature nursery	10.0
Dental departments	3.8	Radioactive isotope therapy department	3.4
Electrocardiograph service	13.8	Social service department	0.8
Electroencephalograph service	3.6	X-ray diagnostic service	14.1
Hospital auxiliary	1.2	Routine chest x-ray on admission	7.7
Medical records department	11.7	X-ray therapeutic service	6.5
Medical staff library	8.5	Accredited by Joint Commission	3.8
Obstetrical delivery room	16.3		
Occupational therapy department	2.9		
Operating rooms	14.9		

Of all proprietary short-term general hospitals, 12.1 per cent were accredited by the Joint Commission on Accreditation of Hospitals.

CLASSIFICATION OF PROPRIETARY HOSPITALS IN THE UNITED STATES



PROTOTYPE STUDY:

25 BED PROPRIETARY HOSPITAL

The prototype study by Dr. Block of the proprietary short-term general hospital starts with this article on the 25 bed hospital. Succeeding articles will take up proprietary hospitals of other bed capacities. Where com-

parable studies have been made, each article will be accompanied by a comparison between the nonprofit and the proprietary short-term general hospital in the same size range.

BED DISTRIBUTION

In most of these hospitals there is no specific bed assignment for special patient groups. Where more than 50 per cent of the hospitals within this

size group make such an assignment, they are considered as having specific bed assignments for purposes of this study. Where bed assignments

occur in less than half of these hospitals, they are considered as unassigned. The following tabulation shows the assigned or unassigned service

Medical-surgical patient beds

- a. Frequency of occurrence... No hospitals
- b. Average number of beds assigned None

Obstetrical patient beds

- a. Frequency of occurrence... Almost 1 in 2 hospitals
- b. Average number of beds assigned 6

Pediatric patient beds

- a. Frequency of occurrence... 1 in 4 hospitals

groupings, the frequency with which they occur, and the average number of beds that are assigned to them:

- b. Average number of beds assigned 3

Isolation or contagious patient beds

- a. Frequency of occurrence... 1 in 10 hospitals
- b. Average number of beds assigned 2

Psychiatric patient beds

- a. Frequency of occurrence... 1 in 100 hospitals

Tuberculosis patient beds

- a. Frequency of occurrence... 1 in 100 hospitals

UTILIZATION

An analysis of the kind, type and number of patients admitted to and using the 25 bed proprietary general hospital annually shows 900 to 950 admissions, 36 to 38 admissions per bed, 170 live births, 5000 patient days of care, and 900 newborn infant days of care.

The adult daily census in the 25 bed proprietary general hospital is 14, while the daily newborn census is 2.5.

The percentage of adult occupancy, therefore, is 55 and the average length of stay for patients is 5.0 days.

SERVICES

Where services are provided in more than half of these hospitals they are considered as being available in terms of this study. Services that might be provided but which are found to occur in less than 50 per cent of these facilities are con-

sidered as unavailable. Certain of these services may be provided through arrangements with other hospitals and sources. Such arrangements, however, are not reflected in the frequencies shown in the following tabulation:

Frequencies of Hospitals Offering:	Per Cent of Hospitals
Clinical laboratory	88
Basal metabolism apparatus	83
Electrocardiograph	83
Central sterile supply room	60
Blood bank	32
Electroencephalograph	2
Dental department	8
Hospital auxiliary	4
Medical records department	66
Operating rooms	94
Obstetrical delivery rooms	86
Medical staff library	33
Pharmacy	26
Physical therapy department	24

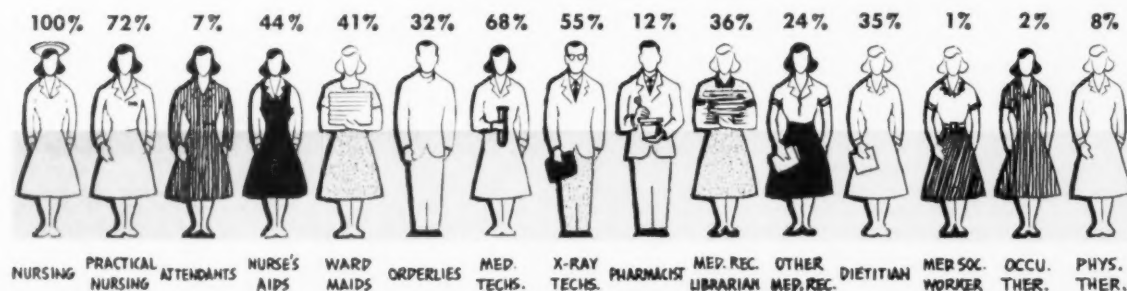
	Per Cent of Hospitals
Postoperative recovery room	12
Occupational therapy department	4
X-ray diagnosis	93
X-ray therapy	10
Premature nursery	25
Radioactive isotope therapy department	2
Routine chest x-ray on admission	22
Social service department	2
Outpatient department	47
Patients' library	16
Cancer clinic	2
Rehabilitation department	0
Children's educational program	3
Mental hygiene clinic	0

PERSONNEL

The number of full-time personnel employed by the prototype 25 bed proprietary short-term general hospital is 24. The number of full-time

personnel per 100 patients is 171, with the number of full-time employees per bed 0.96, and the number of full-time employees per occupied bed 1.7.

PERCENTAGE OF 25 BED HOSPITALS HAVING THE FOLLOWING PERSONNEL



Only one hospital in 25 has an organized auxiliary. For those having an organized auxiliary the average membership is 28 while the average number of auxiliary members working in the hospital is 12 to 13. The number of persons other than hospital auxiliary contributing voluntary service in the hospital is 5.

The prototype proprietary 25 bed hospital employs one graduate nurse as a nursing administrator, one as a supervisor or one as a head nurse. The graduate nurse staff totals seven persons.

Three general duty full-time nurses are employed in the hospital, making up 44 per cent of the graduate staff. Only one general duty part-time nurse is employed. None or less than one of

the nurses would be available for private duty. The average number of other nursing personnel at the prototype hospital having other nursing personnel is: practical nurses, 6; attendants, 2; nurse's aides, 5-6; ward maids, 2; orderlies, 2.

Where they are employed at all (see chart on page 79), the hospital has one each of the following full-time employees: pharmacist, medical records clerk, dietitian and medical social worker. In the hospital having a medical technologist, x-ray technician, medical record librarian, occupational therapist, and physical therapist, these employees would be trained on the job, since the hospitals did not report a significant number of professionally trained employees in these classifications.

OPERATING ROOMS

The prototype hospital has two operating rooms,

one major and one minor operating room.

COMPARISON OF 25 BED PROPRIETARY GENERAL HOSPITAL

THE following indicates certain areas of similarity and difference between a 25 bed nonprofit and a 25 bed proprietary general hospital.

BED DISTRIBUTION

1. The nonprofit hospital is more likely to make specific bed assignments for medical-surgical patients.
2. More than half in each control group make a specific bed assignment for obstetrical patients. The average number of beds so assigned is less in the proprietary hospital.
3. The proprietary hospital more frequently makes a specific bed assignment for pediatric patients. The average number of beds so assigned is less than in the nonprofit hospital.

UTILIZATION

1. Utilization of facilities is less in the proprietary hospital than it is in the nonprofit hospital as evidenced through a lesser number of admissions, births, patient days of care, census, occupancy and patient stay.

SERVICES

1. This size hospital in both control groups usually provides a clinical laboratory, metabolism apparatus, electrocardiograph, central supply room, medical record department, and x-ray diagnosis.
2. In addition, the nonprofit hospital will have an outpatient department.

FINANCIAL

1. Both total assets and plant assets are less in the proprietary hospital. Despite this, the proportionate relationship of plant assets to total assets is greater in the proprietary hospital.
2. Both total income and patient income are greater in the proprietary hospital.
3. Although total expenses are about the same in both the proprietary and nonprofit hospital, payroll expenses are less in the proprietary hospital.
4. The proportion of payroll to total expense is less in a proprietary hospital while expense per patient day and payroll per patient day are greater.

PERSONNEL

1. The number of total full-time personnel per 100 patients, per bed, and per occupied bed are about the same for both groups.
2. The proprietary hospital is less likely to have an organized auxiliary.
3. The average number of volunteers contributing service to the hospital is smaller in the proprietary hospital.
4. Total graduate nursing personnel is lower in the proprietary hospital. This is reflected in a lesser number of general duty nurses. Similarity in both groups exists with regard to administra-

tive graduate nursing personnel, supervisors and assistants, and head nurses and assistants.

5. Both groups show similarity in the number of private duty nurses.
6. The proprietary hospital shows a greater number of practical nurses and a lesser number of nurse's aides.
7. In those hospitals that have them, there is similarity in the number of attendants, ward maids and orderlies, medical technologists, x-ray technicians, medical record librarians, dietitians, medical social workers, and physical therapists.
8. Although, in those hospitals that have them, there is similarity in the number of pharmacists, other medical record personnel, and occupational therapists, the proprietary hospital is more likely to have such employees on a full-time basis while the nonprofit hospital is more likely to have them on a part-time basis.

MEDICAL STAFF

1. The nonprofit hospital shows a greater degree of organization of the medical staff as evidenced in committees established.
2. The nonprofit hospital is more likely to have surgical restrictions on the staff.
3. The proprietary hospital is more likely to provide service for private patients of the medical staff.
4. The nonprofit hospital is more likely to be accredited by the Joint Commission on Accreditation of Hospitals.
5. The proprietary hospital has fewer staff physician appointments, especially with regard to active and associate staffs.

NURSERY

1. The proprietary hospital has a smaller number of bassinets.
2. The nonprofit hospital is more likely to have special nurseries for premature infants.
3. Although the nonprofit hospital is more likely to have infant incubators, both groups provide the same number when they do have them.

ADMINISTRATOR

1. The proprietary hospital is more likely to have a physician as administrator while the nonprofit hospital is more likely to have a nurse or other person as administrator.
2. In the nonprofit hospital the administrator is more likely to be a graduate of a college course in hospital administration than is the administrator of a proprietary hospital.
3. In the proprietary hospital the administrator is more likely to be a male, while in the nonprofit hospital the administrator is more likely to be a female.
4. Administrative responsibility is more frequently delegated to the night nursing supervisor in the nonprofit hospital than in the proprietary hospital.

ADMITTING

Admitting records are duplicated by a typewriter in 43 per cent of the hospitals studied, by a mimeograph in 1 per cent, and by hand in 49 per cent. None of the 25 bed hospitals uses

the liquid and gelatin or plate imprint methods. The following percentage of the 25 bed proprietary hospitals routinely treat patients with the indicated diagnosis:

	Per Cent of Hospitals
Alcoholic	17
Cancer	50
Cardiac	74
Dermatologic	46
Drug addiction	4
Epileptic	14
Gynecologic	67
Isolation (contagion)	13
Medical	94
Mentally deficient	3
Neurologic	21
Obstetric	87
Ophthalmic	32
Orthopedic	66

	Per Cent of Hospitals
Otorhinolaryngologic	34
Poliomyelitis	5
Psychiatric	5
Surgical	90
Tuberculosis	3
Urologic	56
Venereal disease	19
Acutely ill	98
Chronically ill	71
Convalescent and rest	16
Geriatric	31
Industrial	62
Pediatric	79

WITH THE 25 BED NONPROFIT GENERAL HOSPITAL

OPERATING ROOMS

1. Both the proprietary and nonprivate hospital show a similarity in number of major and minor operating rooms.

LABORATORIES

1. Although there is similarity in the frequency with which these hospitals have physician staff members specializing in pathology, the pathologist is more likely to be full time in the nonprofit hospital and part time in the proprietary hospital.

2. There is similarity in both control groups in the frequency with which these hospitals require urinalysis on all admissions, serological examinations for syphilis on adult admissions, electrocardiograph on all admissions over 45 years of age, and preoperative coagulation on all tonsillectomies.

3. The nonprofit hospital more often requires blood counts on all admissions.

4. The proprietary hospital more often requires that all tissue removed at surgery be routinely examined by a pathologist, that Rh groupings be made on all pregnancy cases, preoperative urinalysis made on all surgical cases, and postoperative urinalysis done on all surgical cases.

RADIOLOGY

1. Although the nonprofit hospitals of this size show a greater frequency of physician staff members specializing in radiology, they are likely to have a greater proportion of them on a part-time basis than is the proprietary hospital.

PHARMACY

1. Although a greater proportion of the proprietary hospitals operate pharmacies and have a drug formulary than such nonprofit hospitals, they are less likely to have a full-time pharmacist.

OUTPATIENT DEPARTMENT

1. The proprietary hospital shows a greater number of outpatient and emergency visits.

MEDICAL RECORDS

1. The nonprofit hospital is more likely to microfilm medical records.

2. Proprietary hospitals more frequently use the "Standard Nomenclature of Diseases and Operations."

DEATHS AND AUTOPSIES

1. Although the per cent of autopsies is the same in both groups of hospitals, the proprietary hospital shows fewer deaths and autopsies.

ADMITTING

1. The proprietary hospital is less likely to routinely admit pa-

tients with special diagnoses except for those classified as psychiatric, venereal disease, and industrial.

ACCOUNTING

1. The proprietary hospital more frequently calculates depreciation but funds it less frequently than does the nonprofit hospital.

2. The proprietary hospital less frequently operates under formal budgets and less frequently uses the American Hospital Association chart of accounts.

PURCHASING

1. Although the frequency with which both groups have a central purchasing department is the same, the proprietary hospital is more likely to have a full-time purchasing agent.

PUBLIC RELATIONS

1. In general, the proprietary hospital is less likely to employ methods of obtaining opinions concerning the hospital than is the nonprofit hospital.

DIETARY

1. The proprietary hospital is more likely to provide a selective menu for all patients.

LAUNDRY

1. The proprietary hospital is less likely to operate a laundry than in the nonprofit hospital.

2. In those hospitals which operate their own laundry and process all soiled linen there is similarity in the number of pounds processed in total and on a per-patient-day basis.

3. In those hospitals having laundry done outside the hospital the proprietary hospital shows a lesser amount on both a total pound and on a per-patient-day pound basis.

SAFETY

1. The proprietary hospital more frequently has an organized safety committee and written fire, emergency and evacuation plans.

2. Both groups show a similarity in frequency with which they hold regularly scheduled fire drills.

RELIGIOUS

1. The proprietary hospital is less likely to provide religious facilities such as a chapel or a meditation or prayer room than is the nonprofit hospital.

2. The same is true with regard to chaplain or visiting clergy services.

AMBULANCE

1. The proprietary hospital more frequently provides ambulance service. This is true in the use of private, nonhospital ambulances. They are less likely to operate their own ambulances.

FINANCIAL

Total assets	\$107,500	Patient income per patient day	\$22
Total assets per bed	\$4,300	Per cent patient income of total income	92%
Plant assets	\$90,000	Total annual expenses	\$105,000
Plant assets per bed	\$3,600	Total expenses per patient day	\$21
Per cent plant assets of total assets	84%	Annual payroll expenses	\$50,000
Total annual income	\$120,000	Payroll expense per patient day	\$10
Total income per patient day	\$24	Per cent payroll of total expenses	48%
Annual patient income	\$110,000		

ACCOUNTING

Depreciation is calculated in 86 per cent of the hospitals, the depreciation being funded in 18 per cent. Ten per cent of the hospitals operate under

formal budgets and 24 per cent use the American Hospital Association chart of accounts.

MEDICAL STAFF

Frequency of Hospitals Having:	Per Cent of Hospitals		Per Cent of Hospitals
Chief of staff	82	Credentials committee of staff	10
Chiefs of services	33	Tissue committee of staff	6
Written staff regulations	49	Education committee of staff	2
Regular staff meetings	52	Pharmacy committee of staff	3
Standing staff committees	22	Dietary committee of staff	7
Executive staff committee	23	Nursing committee of staff	13
Medical record committee	16	Psychiatrist on staff	17

In those hospitals having psychiatrists on the staff, 25 per cent treat only inpatients.

Surgical restrictions are placed on the staff by 53 per cent of the hospitals. Nonstaff members are permitted to practice in 58 per cent of the hospitals.

Examining rooms for ambulatory patients of medical staff are provided in 70 per cent of the hospitals; private physicians' offices in or on hospital grounds are provided in 47 per cent; x-ray facilities are available for private ambulatory patients of staff in 88 per cent, and laboratory services are available to private ambulatory patients of staff in 85 per cent.

Six per cent of the 25 bed hospitals studied had

received accreditation by the Joint Commission on Accreditation of Hospitals.

The number of staff physician appointments averaged 13, including: active staff, 6-7; associate staff, 1; courtesy staff, 3; consultant staff, 2-3; honorary staff, 0.

The number of staff physician appointments per 100 beds averaged 52, divided as follows: active staff, 26; associate staff, 4; courtesy staff, 12; consultant staff, 9; honorary staff, 1.

(Where 50 per cent or more of these hospitals had particular staff relationships or services it was considered as being the normal practice in this study. Where less than 50 per cent of these hospitals had them, it was considered not available.)

LABORATORY

Frequency of Hospitals Having:	Per Cent of Hospitals		Per Cent of Hospitals
Physician staff members specializing in pathology	23	Rh grouping on all pregnancy cases	51
Full-time pathologist	3-4	Preoperative blood grouping on all surgical cases	38
All tissue removed at surgery routinely examined by a pathologist	65	Preoperative coagulation on all tonsillectomies	66
Urinalysis on all admissions	79	Postoperative urinalysis on all surgical cases	50
Blood count on all admissions	66	No tests without doctor's orders	18
Serological examinations for syphilis on all adult admissions	41	Laboratory facilities available to private ambulatory patients of physicians	85
Electrocardiograph on all admissions over 45 years of age	4		

RADIOLOGY

Frequency of Hospitals Having:	Per Cent of Hospitals		Per Cent of Hospitals
Physician staff members specializing in radiology	26	X-ray facilities available to private ambulatory patients of physicians	88
a. Full time	7	Chest x-ray on admission	22
b. Part time	19		

(Continued on Page 84)

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DEATHS AND AUTOPSIES

There are 19 deaths annually in the prototype hospital. These deaths make up 2 to 2.1 per cent of admissions.

The number of annual autopsies performed in

the prototype hospital is 1 or 2, being 5 to 11 per cent of the number of deaths. Six of the deaths, or 0.7 per cent of admissions, are released to legal authorities.

LAUNDRY

One in 4 of the hospitals studied operates its own laundry and processes all soiled linen. In these hospitals, 1175 pounds of laundry are processed per week and 61,000 pounds per year, averaging 12 pounds per patient day.

For the hospitals which do not operate their own laundry, 785 pounds are processed per week, or a total of 41,000 pounds in a year, for an average of eight pounds per patient day.

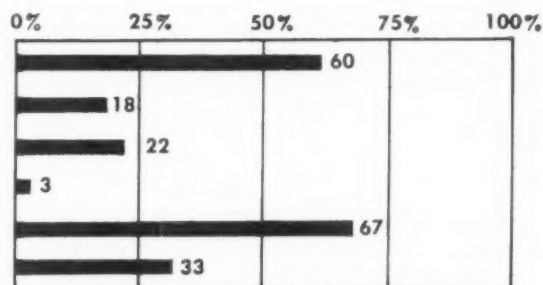
ADMINISTRATOR

There is a full-time assistant administrator in 40 per cent of the 25 bed proprietary hospitals studied. Administrative responsibility is delegated to the night nursing supervisor in 67 per cent

of the hospitals, while an administrative staff member is on duty during the night in 24 per cent of the hospitals.

Frequency of Hospitals:

Where chief administrative officer is a physician	60
Where chief administrative officer is a graduate nurse	18
Where chief administrative officer is other than physician or a nurse	22
Where chief administrative officer is a graduate of a college course in hospital administration	3
Where chief administrative officer is a male	67
Where chief administrative officer is a female	33



SAFETY

An organized safety committee is to be found in 28 per cent of the hospitals studied. Written fire emergency and evacuation plans are found in 41 per cent of the hospitals, while regularly scheduled fire drills are held in 21 per cent of the hospitals. A written plan for mobilization of employees and medical staff is available at 18 per cent

of the hospitals studied. Fifteen per cent of these hospitals have integrated this written mobilization plan into the master community plan. A representative of the hospital sits on the community's disaster planning committee in 40 per cent of the cases.

DIETARY

Frequency of Hospitals With:	Per Cent of Hospitals
Dietitians (full or part time)	35
Central food service layout	97
Decentralized food service layout	3
Selective menus for all patients	38
Selective menus for private patients only	5

	Per Cent of Hospitals
No selective menus	57
Manual and centralized dishwashing	63
Manual and decentralized dishwashing	3
Mechanical and centralized dishwashing	33
Mechanical and decentralized dishwashing	1

NURSERY

The 25 bed proprietary hospital has six to seven bassinets. Thirteen per cent of these hospitals have special nurseries for premature infants, while 64 per cent have infant incubators. In those hos-

pitals having them there are two infant incubators. Bead bracelets are used for identification in 67 per cent of the hospitals; tape bracelets are used in 25 per cent.

RELIGIOUS

None of the prototype hospitals studied furnishes a chapel, and only 2 per cent furnish a meditation or prayer room.

Twenty-six per cent of the hospitals have an organized visiting clergy staff and 45 per cent have a chaplain available on call or assignment.

(Continued on Page 86)

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OUTPATIENT DEPARTMENT

Annual number of outpatient visits.....7600

Annual number of emergency visits..... 500

PURCHASING

A central purchasing department is to be found in 80 per cent of the 25 bed proprietary hospitals.

Of those which have central purchasing, a full-time purchasing agent is employed in 15 per cent.

PUBLIC RELATIONS

Frequency of Hospitals Using:	Per Cent of Hospitals
Booklet for patients.....	10
Booklet for employes.....	7
Regularly published house organ.....	1
Printed annual report.....	5
Patient opinion poll.....	8

	Per Cent of Hospitals
Personnel opinion poll.....	8
Medical staff opinion poll.....	6
Community opinion poll.....	0
No polls.....	86

MEDICAL RECORDS

Only one in 75 of the hospitals microfilms medical records. Three in 4 of the hospitals use the

"Standard Nomenclature of Diseases and Operations."

PHARMACY

One in four of the 25 bed general proprietary hospitals operates a pharmacy. Of these, 1 in 8

has a full-time licensed pharmacist. Almost 1 in 2 of the hospitals has a drug formulary.

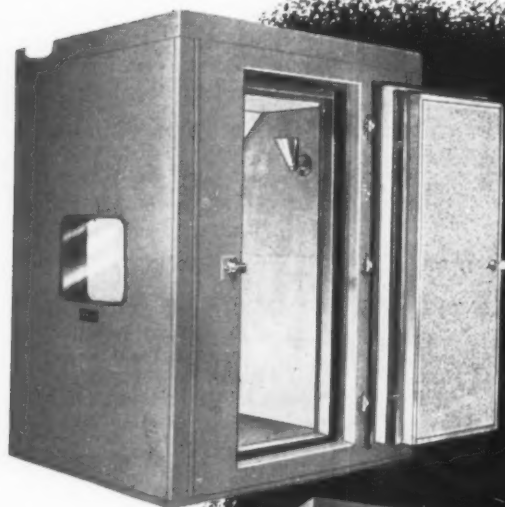
AMBULANCE

Ambulance service is provided in 95 per cent of the hospitals studied although only 2 per cent operate their own ambulances. The others use city

or publicly owned ambulances in 10 per cent of the cases, or private nonhospital ambulances in 83 per cent of the cases.

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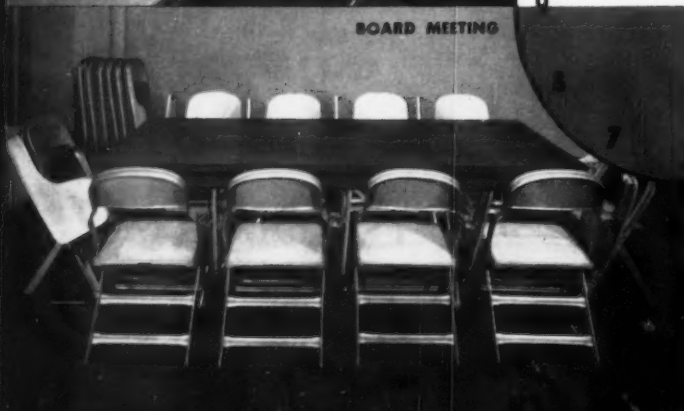
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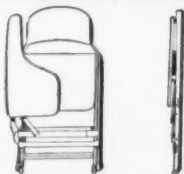
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Reactions Following Use of Influenza Vaccine (Asian Strain) in Adults

Reaction rates from the type of influenza vaccine currently produced and consisting of 200 CCA units of Asian strain per ml. are very low in adults and should not be a deterrent against the use of this vaccine for prevention of influenza. The majority of the reactions appear within five hours after inoculation. Reaction rates are approximately twice as high in the female as compared with the male. Prevention of anaphylaxis in adults due to egg allergy may be accomplished for screening purposes by history of sensitivity to eggs, chicken or chicken feathers. Intradermal skin testing may be reserved for those adult patients who present a questionable history of such allergy.

JOSEPH F. SADUSK Jr., M.D., and GEORGE NESCHE, M.D.

RECOGNIZING the distinct possibility for a serious outbreak of influenza in the San Francisco Bay area during the fall of 1957, the medical advisory board of Peralta Hospital on July 31 appointed a committee consisting of Dr. George Nesche, Dr. Joseph F. Sadusk Jr., and Dr. Arthur Twiss to survey the situation continuously.

The medical advisory board delegated to that group authority to organize and direct an immunization program against influenza if and when the time was appropriate. In view of the similarity existing between the present rapid spread of influenza on a worldwide basis and the situation existing in 1918, the committee put into effect, on August 30, a preplanned program for inoculation of all Peralta

Hospital employees with influenza vaccine, Asian strain.

Since no data are presently available in the literature to indicate the reaction rate to be expected from the currently used influenza vaccine, the Peralta immunization program was planned to yield specific information on this point. Such is the purpose of this article.

Reactions from influenza vaccine⁷ were outlined in the 1940's and were found to be comparable to those seen with typhoid vaccine, annoying but not serious. The local reaction consisted of pain, swelling and redness at the site of inoculation; the systemic reaction was characterized by the presence of fever, headache, chilliness, generalized aching, nausea and vomiting.

While some early reports^{1,3} suggested that methods of production of the vaccine might be the important factor in leading to high or low reaction rates, an exhaustive study on influenza vaccine reactions in 4127 vaccinated individuals by Sadusk, Bassett and Meddaugh⁶ in 1949 demonstrated that the frequency and severity of reactions were not related to the method of production but rather to the total virus content of the vaccine.

These investigators also noted that the important variable in reaction rate and severity of reaction was that of sex. The reaction rate in the female group was found to be twice that observed in the male group, while the severity of reactions observed was four times as high in the female group as in the male.

It was further found that: (1) Previous inoculation with influenza vaccine did not predispose to a higher rate of reactions; (2) the use of acetylsalicylic acid or APC (acetylsalicylic acid, phenacetin and caffeine) tablets did not significantly reduce the reaction rate; (3) employees giving a history of hay fever or asthma showed no higher reaction rate than the remaining individuals of the vaccinated group, and (4) there was need for screening out egg-sensitive individuals. Finally, in the clerical group studied, the reaction rate was significantly higher in the group, 15 to 24 years old, than in groups of persons 25 years old or more, where the reaction rate was constant. This difference was particularly marked in the female population.

The influenza vaccines employed by Sadusk, Bassett and Meddaugh⁶ con-

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Acknowledgements: This study would not have been possible without the aid and cooperation of Dr. Arthur Twiss; George U. Wood, administrator of Peralta Hospital, Oakland, Calif., and his staff in processing forms and reports; Mrs. Judy Collins, director of nursing, in setting up and supervising the inoculation stations, and Drs. John Brandon, William Leedy, Oscar Powell, and Edgar Rosen in the egg-allergy screening.

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*Donnelly, J. F. *North Carolina M. J.* 18:191, 1957.

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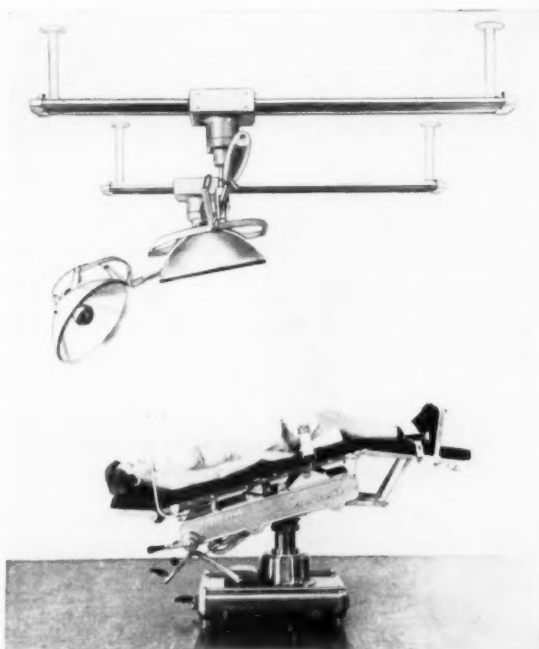
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Table 2—Broad Types of Reaction Following Influenza Vaccine Inoculation in 327 Employees (Male, 55; Female, 272)

	Male		Female	
	Number	Per Cent	Number	Per Cent
Local reaction ¹	16	29.1	97	35.7
Systemic reaction ²	2	3.6	24	8.8
Combined reaction ³	5	9.1	82	30.1
No reaction.....	32	58.2	69	25.4
Total injected.....	55	100.0	272	100.0

¹Local pain, swelling or redness at the site of injection.

²Purely systemic reaction consisting of fever, aching, chilliness, headache, nausea and vomiting.

³Combination of both local and systemic reactions.

Table 3—Specific Types of Reaction Following Influenza Vaccine Inoculation in 327 Employees (Male, 55; Female, 272)

	Male		Female	
	Number	Per Cent	Number	Per Cent
Local Reaction:				
Pain.....	14	25.5	120	44.1
Swelling.....	7	12.7	57	20.9
Redness.....	8	14.5	103	37.9
Systemic Reaction:				
Fever.....	2	3.6	14	5.1
Aching.....	1	1.8	65	23.9
Chilliness.....	2	3.6	27	9.9
Headache.....	4	7.3	59	21.7
Nausea.....	3	5.4	18	6.6
Vomiting.....	0	0	4	1.5

per cent for females. In all, a total of 327 employees out of 410 returned forms.

Type of reactions. Table 2 presents an analysis of broad types of reaction, analyzed by sex difference. In this table, the reaction rates are broken down into local reactions, systemic reactions, and combined reactions. The number and percentage of those employees reporting the absence of any reaction are also noted.

The local reaction consists of local pain, swelling or redness, or a combination of these symptoms at the site of injection. The purely systemic reactions comprise those symptoms of fever, aching, chilliness, headache, nausea and vomiting. Finally, those patients who

reported symptoms of both systemic and local reaction type are listed as combined reactions.

Here, it is clearly evident that there is a marked sex difference. Of the males, 29.1 per cent reported a local reaction as compared with 35.7 per cent of females; 3.6 per cent of males reported a systemic reaction as against 8.8 per cent of females, and 9.1 per cent of males reported a combined reaction as against 30.1 per cent of females.

Absence of reaction of any type was reported in 58.2 per cent of males as compared with only 25.4 per cent of females.

As determined by spot checks through personal interview, reactions

reported were generally quite mild. In Table 3 are presented data for the specific components of the local and systemic reactions. Here again, a marked difference by sex is readily apparent.

Among the local reactions, there is almost a twofold increase in all local reactions for the females as compared with the males. For systemic reactions, this twofold difference generally holds true except for a more striking increase in symptoms such as aching and headache. It should also be noted that none of the males reported vomiting as a symptom, against 1.5 per cent of the females.

In Table 4 are outlined the broad categories of local, systemic and combined reactions analyzed by age groups for male and female.

With regard to the male group, it is obvious that the numbers listed are not statistically valid and little or nothing can be said about this group. With regard to the females, such a detailed breakdown again yields relatively small numbers in each category and age group for analysis; consequently, percentage data are not recorded.

It is of interest, however, that the age group differences as noted in the previous study⁶ are not apparent in the present study. In other words, there does not seem to be an excess number of reactions in the young female group, 15 to 24 years old, as compared with the group 25 years old and older.

Severity of reactions. In Table 5 are presented detailed data on the number of individuals who reported an answer to the question: "Were you ill as a result of inoculation?" Again the figures are small in number, but in the case of the female group, where figures may begin to approach statistical validity, there is no significant dif-

Table 4—Number of Reactions Analyzed by Sex and Age Group as to Whether Reaction was Local or Systemic

Age Group (Years)	Male				Female				No. Injected	
	Local ¹	Systemic ²	Combined ³	None	Local ¹	Systemic ²	Combined ³	None	Male	Female
15-24.....	6	0	1	3	10	3	8	8	10	29
25-34.....	4	1	2	4	20	3	12	5	11	40
35-44.....	2	0	0	4	26	5	17	16	6	64
45-54.....	3	0	1	4	15	7	23	21	8	66
55-64.....	1	1	1	13	20	4	21	13	16	58
64.....	0	0	0	4	5	1	0	2	4	8
Not stated...	0	0	0	0	1	1	1	4	0	7
Total.....	16	2	5	32	97	24	82	69	55	272

¹Local pain, swelling or redness at the site of injection.

²Purely systemic reaction consisting of fever, aching, chilliness, headache, nausea and vomiting.

³Combination of both local and systemic reactions.

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ference in "illness" rate in the younger group as compared with the older group. One of the striking points is the relative absence of "illness" in the older age group (more than 64 years), but here again the number of individuals available for analysis is small.

The severity of reactions may be approached from two aspects, namely, the employee's response to the question: "Were you ill as a result of inoculation?" and his or her absence from work as a result of the inoculation. Such data are reported in Table 6 with a breakdown by sex to indicate whether such differences are present. With regard to "illness," the difference in "illness" rate is striking, with only 1.8 per cent of males reporting that they were "ill" as a result of the inoculation as compared to 9.6 per cent of the females who answered the question in the affirmative.

If one takes into account even a more strict definition for severity of reaction, such as absence from work, the data in Table 6 indicate that only 1.1 per cent of females were absent as a result of the inoculation. In this instance, one female was absent

Table 5—Employees' Reply to "Illness" Statement Analyzed by Sex and Age Group

Age Group (Years)	Male			Female			No. inoculated Male and Female Total
	Ill*	Not Ill	Total	Ill*	Not Ill	Total	
15-24.....	0	10	10	1	28	29	39
25-34.....	2	9	11	4	36	40	51
35-44.....	0	6	6	5	59	64	70
45-54.....	0	8	8	9	57	66	74
55-64.....	0	16	16	5	53	58	74
64.....	0	4	4	0	8	8	12
Not stated.....	0	0	0	0	7	7	7
Total.....	2	52	55	24	248	272	327

*Affirmative answer of employees to question: "Were you ill as a result of influenza vaccine inoculation?"

for one day, one for two days, and one for three days. It should be noted that one of the three females who was absent from work reported an illness beginning four days after inoculation, consisting principally of systemic symptoms such as fever, aching, nausea and vomiting. It is of course highly probable that this was an intercurrent non-specific gastrointestinal infection and was not due to the influenza inoculation.

One male, who is not represented in this table, indicated that on the seventh day after inoculation he contracted an illness characterized by

fever, chilliness and headache which necessitated a three-day absence from work. Such an illness beginning seven days after inoculation could not possibly be ascribed to the influenza vaccine, and hence is not included in the table.

Time of appearance of reaction.

It will be noted in Table 7 that the great majority of reactions from influenza vaccine appeared within five hours after injection; indeed, the greater proportion actually appeared within one or two hours.

It is to be noted that the reaction rate drops off sharply after the fifth

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Table 6—Severity of Reaction (Subjective "Illness" and Absenteeism) Following Influenza Vaccine Inoculation of 327 Employees (Male, 55; Female, 272)

	Male		Female	
	No.	Per Cent	No.	Per Cent
"Illness" ¹	1	1.8	26 ¹	9.6
Absence From Work.....	0 ²	—	3 ³	1.1
1 day.....	0	—	1	—
2 days.....	0	—	1	—
3 days.....	0	—	1	—
More Than 3 days.....	0	—	0	—
Not stated.....	0	—	0	—

¹Employees who gave an affirmative reply to the question: "Were you ill as a result of influenza vaccine inoculation?"

²One male, reporting an illness on 7th day after inoculation characterized by fever, chilliness and headache, necessitating a total of 3 days' absence, is not included in table.

³One female reporting an illness beginning 4 days after inoculation, with fever, aching, chilliness, nausea and vomiting, included in table, but probably does not represent a reaction to influenza vaccine.

hour, but begins to rise between 12 and 24 hours after inoculation. It is of course extremely dubious as to whether the 9.6 per cent of total male and female reactions appearing longer than 24 hours after the inoculation are due to the vaccine. Here, one strongly suspects that intercurrent acute respiratory diseases play a rôle. It can be stated that throughout the Oakland area, both prior to, during and following vaccination, a nonspecific type of acute respiratory disease appeared to

Table 7—Time of Appearance of Reaction Following Inoculations With Influenza Vaccine in 135 Employees Returning Information on This Point, Analyzed by Sex Difference

Time of Appearance	Male		Female		Male and Female	
	No.	Per Cent	No.	Per Cent	No.	Per Cent
1-2 hrs.....	4	28.6	50	41.4	54	40.0
3-5 hrs.....	5	35.7	25	20.6	30	22.2
6-8 hrs.....	2	14.3	8	6.6	10	7.4
9-12 hrs.....	0	—	7	5.8	7	5.2
12-24 hrs.....	1	7.2	20	16.5	21	15.6
24 hrs.....	2*	14.2	11	9.1	13	9.6
Total.....	14	100.0	121	100.0	135	100.0

*One additional male reported appearance of "reaction" on 7th day after inoculation and is not included

be in higher incidence than one would ordinarily expect.

Possible allergy to influenza vaccine. As noted in the previous studies,^{2,3,4,5} possible allergic reactions to influenza virus must be considered. Since the vaccine is prepared from embryonated chicken eggs, it necessarily contains egg protein which, though minimal in quantity, could theoretically produce an anaphylactic shock in an individual who was highly allergic to egg protein.

Consequently, the physicians who interviewed the persons subjecting themselves for influenza immunization

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Table 8—Number of Individuals Potentially Allergic by History Among 327 Employees Inoculated With Influenza Vaccine (male, 55; female, 272)

	Male	Female	Total
Inoculation initially deferred for skin testing	4	17	21
Skin-tested with negative test and were inoculated	2	12	14
Did not return for skin test	2	5	7

were requested to be very conservative in regard to the possibility of egg or chicken allergy. They were asked, if there were any doubt in their mind, to defer the patient until skin testing could be carried out.

As will be noted in Table 8, inoculation was initially deferred for intradermal skin testing in 21 employees, of which four were male and 17 were female. Seven employees did not return for skin testing, while 14 did return. These 14 were all found to be negative with the intradermal skin test as outlined, and all were inoculated. No re-

actions, either immediate or delayed, were reported.

DISCUSSION

Data presented in the accompanying tables would indicate that all types of reaction rates and severity of reaction as determined either by reported "illness" or absenteeism are significantly lower than previously reported for polyvalent influenza vaccines.

Since it is now generally accepted that the reaction rate is directly proportional to the amount of total virus content, one would necessarily expect that the reaction rate with the present vaccine containing only 200 CCA units per ml. would be definitely lower than previous reaction rates with influenza vaccine of polyvalent type and containing up toward 1400 or 1500 CCA units per ml.

The significantly marked sex difference in reaction rates confirms previous observations.^{1,6} The reason for this is not clear and deserves further study.

It would appear that the danger of troublesome reactions from the present influenza vaccine is extremely small. In addition, the absenteeism rate is nil for males and approximately 1 per cent for females. Consequently, in large-scale immunization programs among hospital personnel, important civil servants such as police, firemen, school teachers, and utility employees, the fear of reactions preventing full efficiency of the force is to be discounted, particularly so when one assumes a morbidity rate of 20 per cent or more during an influenza epidemic, with an individual employee time loss of from five to fourteen days resulting from influenza.

While no evidence was found for serious acute allergic manifestations in this study, this possible danger must be kept in mind. Influenza vaccination, both on an individual and on a mass basis, should clearly take into account the need for appropriate screening procedures to defer or reject individuals with egg allergy. If one is in doubt concerning an applicant for immunization, skin testing should be carried out, an intradermal test with 0.02 ml. of a 1:10 normal saline dilution of the vaccine being utilized.

The present study and the one previously reported by Sadusk, Bassett and Meddaugh⁶ clearly indicate that routine skin testing of all adults for egg sensitivity is not necessary, as has been suggested by Curphey,² and by Ratner and Untracht,^{4,5} for children, and

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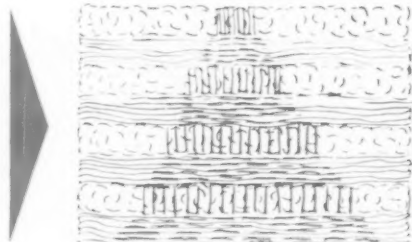
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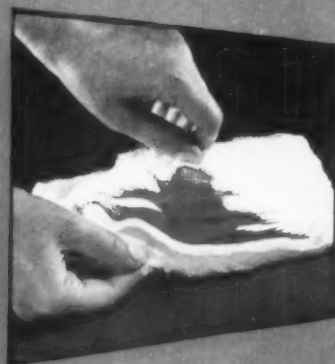
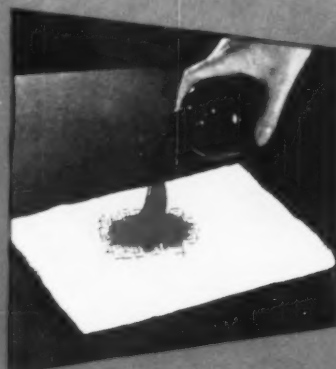
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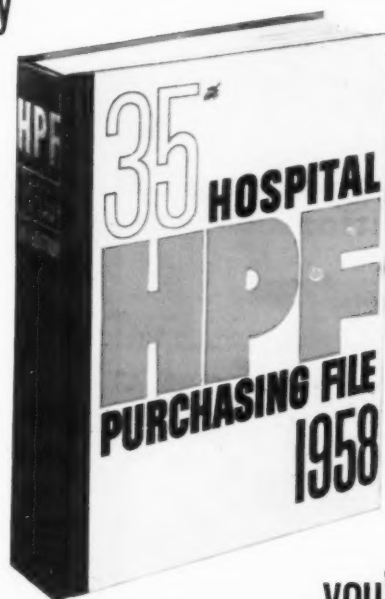
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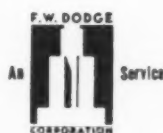
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several of the brochures of the manufacturers accompanying the vial of vaccine. Careful questioning as to symptoms of allergy to eggs, chicken or chicken feathers should be sufficient as a screening procedure for adults.

It is to be emphasized that this recommendation may not necessarily apply to children where the incidence of egg allergy^{4,5} seems to be significantly higher than in adults.

SUMMARY

A study of reactions following influenza vaccine inoculation of 327 em-

ployes of Peralta Hospital, of which 55 were males and 272 were females, revealed a very low value for significant or severe reactions. The reaction rate as observed with the present monovalent vaccine containing 200 CCA units of Asian strain, Type A influenza virus is considerably lower than that reported with previous polyvalent vaccines containing up toward 1400 or 1500 CCA units of total virus content.

An absenteeism rate of only 1.1 per cent in females was observed, and the absenteeism rate in the small number of males studied was nil.

Local reactions such as pain, swelling or redness at the site of injection were found in 29.1 per cent of males and 35.7 per cent of females. Systemic reactions, consisting of fever, aching, chilliness, headache, nausea and vomiting were found in 3.6 per cent of males and 8.8 per cent of females. A combined reaction consisting of both local and systemic reactions together was found in 9.1 per cent of males and 30.1 per cent of females. No reactions of any type were observed in 58.2 per cent of males and 25.4 per cent of females.

The local reactions observed consist principally of pain and redness at the site of injection, and the systemic reactions consist principally of aching and headache.

A marked sex difference in reaction rate was found, confirming previous studies, and shows that the reaction rate is approximately twice as high in the female as in the male.

The greater majority of reactions appear within five hours following inoculation with influenza vaccine.

The prevention of anaphylactic reactions in the adult resulting from the minimal amount of egg protein in influenza vaccine can be accomplished by screening for history of egg, chicken or chicken feather allergy. In questionable cases, the patient may be tested with an intradermal injection of vaccine diluted 1:10 with normal saline.

The reaction rate for the present influenza vaccine is so low that it should not prove a deterrent to immunization with influenza vaccine.

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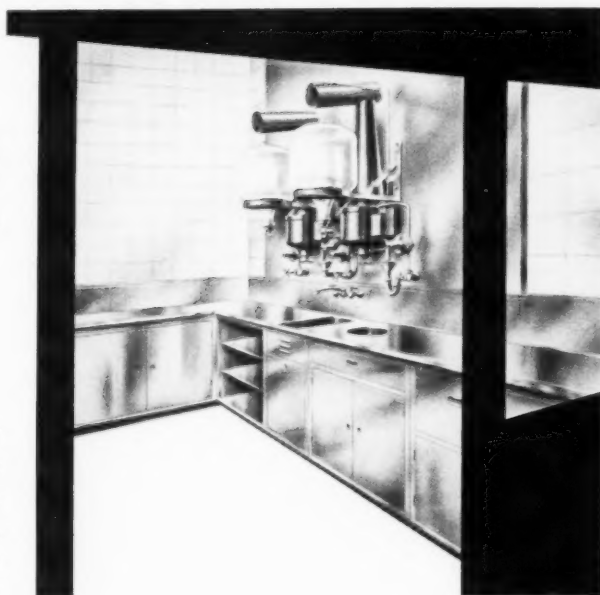
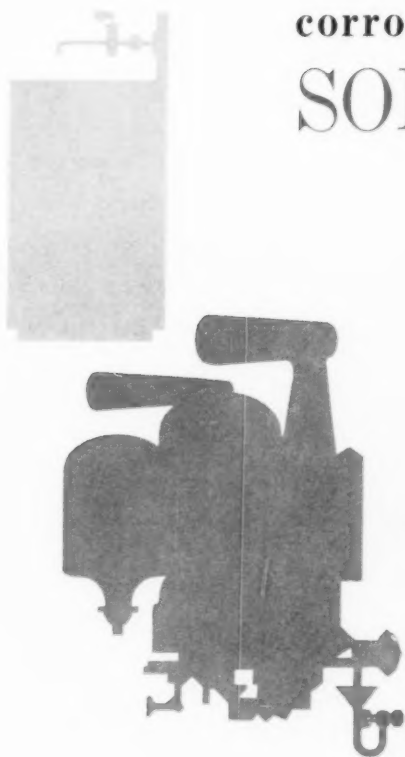
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Patients and Staff Need Facts About Food

Much misinformation about nutrition is spread around not only by laymen but by people who should know better, including hospital employees. The author tells how the dietitian can help educate patients and employees to the facts about food and thus counteract some diet fads

JESSIE C. OBERT

THE hospital chaplain was saying good-by to the patient. "You're very pale, Mrs. Brown, perhaps you are anemic. Have you ever used blackstrap molasses? It's good for anemia because of the iron."

The nurse's aide was settling the patient for the night. During this time she and the patient visited in friendly fashion. The conversation turned to food and in answer to a question the aide said: "Oh, yes, everyone should take vitamin pills. The way they grow food these days in worn-out soil it just isn't as good as it used to be."

The orderly was near the end of the line in the employees' cafeteria. As he reached for the cherry pie, the counter girl said: "You know, Fred, I wouldn't eat that cherry pie and cream soup at the same meal; cherries and milk together might make you sick. And you ought to eat baked potato instead of mashed; there are no calories in baked potatoes."

Exaggerated? No. Advice about food is given every day in such ways by well meaning persons. These examples illustrate the widespread interest in food and its fundamental importance in our lives. They also show us some of the ways in which food misinformation may be spread in the hospital.

Every dietitian sees the results of food misinformation in the hospital and food clinic. Recently reported examples included a nurse who chose queer combinations of food, and a kitchen employee who ate "only starchy

foods or protein foods at one meal." Other dietitians have been concerned when physicians have left patients on inadequate or unpalatable therapeutic diets for long periods of time.

Let us first define some of the terms that must be used in a discussion of food misinformation.

HOW FOOD, NUTRIENTS ARE RELATED

Food is the form in which we eat *nutrients*, the substances needed by the body for growth, maintenance and repair. These nutrients include proteins, fats, carbohydrates, vitamins, minerals and water. Foremost scientists have prepared the Table of Recommended Dietary Allowances as a guide to amounts of the various nutrients each of us should consume daily. From this table the U. S. Department of Agriculture has prepared lists of foods showing combinations and quantities of foods that will provide these nutrients. The actual foods consumed are less important than the nutrients, or, to put it another way, it makes no difference whether nutrients come from one food or from another just as long as the individual gets enough of each kind.

Nutrition is the special branch of scientific study that covers foods and the way they are used by the body. Actually, a knowledge of nutrition is not necessary in order to eat a good diet. We eat *food*, so by selecting the right foods we can eat enough of the necessary nutrients without ever knowing a vitamin from a mineral or a calorie from an amino acid. However, nutrition tells us why the different

food groups are important, and information about nutrition in general and about a particular vitamin or mineral and its rôle in the body is one of the powerful motivating factors which influence the choice of foods by most individuals.

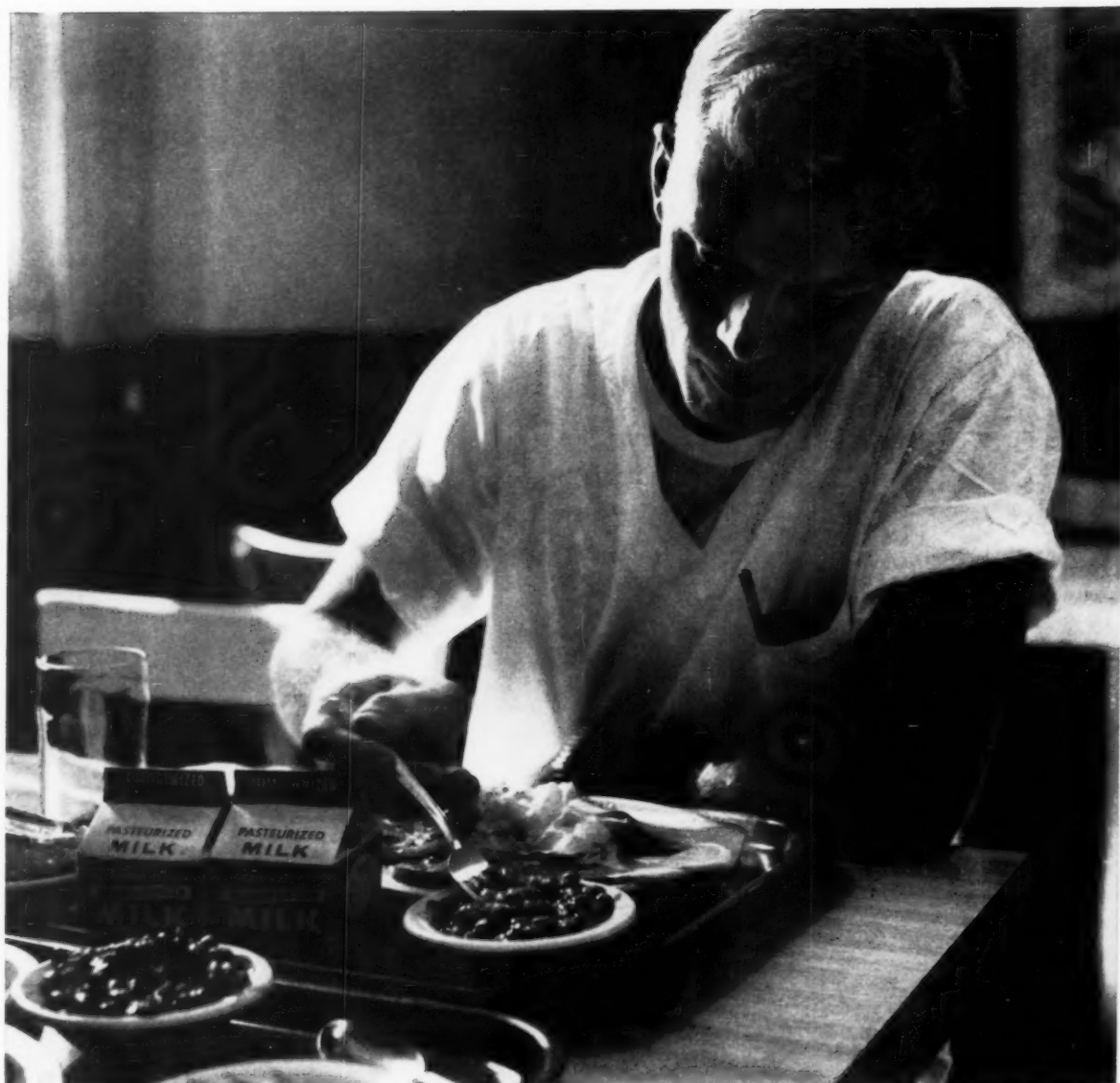
Dietetics is the application of the principles of nutrition to the feeding of individuals or groups.

Food misinformation includes any information about food or nutrition based on misinterpretation of scientific data, folklore or other nonscientific matter. It is harmful when it motivates an individual to eat an inadequate or unbalanced diet, to spend too much of limited funds on expensive foods or food supplements, or to delay seeking medical advice while he tries to cure his ailments by diet. Food misinformation is often based on an extreme point of view such as overemphasis on one food or food group. Another common source is basing general conclusions on the results of one scientific study.

Let us consider some of the reasons advice about food is given so freely by untrained persons and the reasons that such advice is accepted without question by others.

Everyone eats; therefore, everyone "knows something" about food. Often this "knowledge" is based on generalizations drawn from limited personal experience or from a scanty acquaintance with the literature. Much of it, like the previous examples, is based on fads spread by popular writers or speakers, on half-truths designed to promote the sale of special foods or

The author is head public health nutritionist for the Los Angeles County Health Department, Los Angeles.



It's easy to control costs and end waste with Heinz Beans because you open only as many tins as you need

POPULAR HIGH PROTEIN SIDE DISH 3½¢ PER SERVING: HEINZ BEANS

From the nutritional viewpoint alone, you couldn't get a better buy than Heinz Beans. They're high in protein, low in cost. A four-ounce serving costs only 3½¢. What other protein food can you buy—ready to eat, with all the preparation and cooking done for you—for under 14¢ a pound? Just as important, of course—everybody *likes* Heinz Beans. The 54-ounce Chef-Size tin makes cost control simple. Cuts labor costs, too. Just heat and serve. There's no waste, no leftovers. Order Heinz Beans on your Heinz Man's next call.



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BEANS

YOU KNOW IT'S GOOD BECAUSE IT'S HEINZ

food supplements, or on folklore. This kind of information is an ever present challenge to the dietitian and has important implications for the administrator, the food service supervisor, and other hospital personnel.

Probably most persons are aware that food selection should be determined by nutritional needs. However, few have sufficient information to evaluate the bewildering array of information they see and hear every day. Some accept what they read in the newspapers and magazines and what they hear on television and radio with insufficient evaluation of the source or the motives of the authors.

Many persons assume that every physician, dentist, dental hygienist, nurse and food service supervisor is an authority on nutrition because each is concerned about diet. However, in this age of specialization few persons can have a comprehensive scientific knowledge of nutrition. Those trained in the professions just mentioned have had some study of nutrition as part of their curriculum, but the amount is necessarily limited. Unfortunately, not all members of these professions are aware of the vast body of scientific knowledge in nutrition or of its dynamic character; hence some base their beliefs on food misinformation rather than on a realistic interpretation of this knowledge. They could help promote sound nutrition practices by being sure their information comes from scientifically sound sources.

The furor over the Fabulous Formula for reducing provides a good example. As a result of the reports in the popular press some nurses went on this reducing diet, ignoring the statements in the medical press that it was designed for use only under close medical supervision. This illustrates the strong emotional appeal of food and the universal desire for an easy diet that will improve personal appearance in almost magic fashion, "magic" perhaps in its radical departure from regular eating patterns.

Actually, the dietitian is the one member of the medical team whose training makes her a specialist in nutrition and dietetics. The hospital administrator can utilize this knowledge by creating opportunities for the dietitian to pass along a working basis in nutrition to staff and patients. Most hospital employees may be divided into two groups in relation to their knowledge about food and nutrition: (1) professionally trained persons, such as

physicians and nurses, who have had some basic training in nutrition and dietetics, and (2) aides, kitchen employees, and others, who have had little or no formal training in the subject. Probably all of these persons are influenced by popular sources of information. Let us then consider the sources of information for clues to the ways these persons can be influenced to spread sound information.

Recently I made an informal survey among dietitians to find out how food misinformation is spread and why it is accepted by the general public. According to the dietitians who reported, most misinformation about food and nutrition is spread by the various mass communications media—the popular press, television and radio—with health food stores running second.

WHO SPREADS MISINFORMATION?

These dietitians were asked to indicate what persons actually communicate the information through these media. The tabulation pointed first to manufacturers and salesmen, second to self-styled "dietitians" and "nutritionists," and third to members of various professions, such as physicians, nurses, dentists, dental hygienists, chiropractors and others.

The survey also asked who believes the misinformation spread through these channels. The consensus was that the average individual accepts as truth what he reads about food on the printed page, whether in an advertisement, a news story, or a feature column, and believes what he sees and hears on television and radio.

If this is true, it begins to seem clear why people follow the various fad diets for reducing used by movie stars and quoted in beauty columns, why they accept the virtues of the "six wonder foods" as described in a popular book, why they believe that raw vegetables have fewer calories than cooked vegetables, a "fact" disseminated on television by a well known character from the world of the animated cartoon.

What can be done in the hospital to offset the effects of misinformation through such channels? We must realize that information about nutrition is put into practice in food selection and consumption, and that much information and advice about food and nutrition will be given in informal conversation by persons with limited training in nutrition, such as those already mentioned. Then our channel for

sound information in the hospital must be found through these persons. How can the dietitian teach basic nutrition to the employees and promote good food practices among employees and patients? How can the dietitian and other staff members influence patients to follow a prescribed diet, either therapeutic or normal? In order to accomplish this objective the dietitian will need to use every means at hand to give basic information to staff, employees and patients and to motivate them to eat a good diet.

The hospital administrator, concerned that his institution be recognized by scientific groups as a source of sound information and treatment, must be concerned with the kind of dietetic information dispensed in his bailiwick. If his hospital also is active in research, he has an even greater concern for scientific truth.

It is important that he utilize the peculiar contribution of the dietitian as an administrator and technical specialist by enabling her to devote her time to over-all supervision and staff education. This will include inservice training of staff members to provide them with technically correct information on food and nutrition and to develop in them a point of view that will help them recognize misinformation and regard it with skepticism.

Individual employees may be encouraged by their supervisors to practice good food selection in the cafeteria and to refrain from giving advice on diet therapy or on the technical phase of nutrition. They should be taught that diet is as much a part of treatment as medicine and that they would no more prescribe foods than they would prescribe medicine. Suitable, authentic reference materials should be readily available to provide facts about food and nutrition and material for checking information from various sources. Employees can wield important influence by encouraging the patient to follow the diet recommended for him, and they can also urge patients and fellow employees to obtain their facts from sources recommended by the dietitian or to check information from other sources with her.

The dietitian will need to utilize every means provided by the hospital to teach correct information and to promote good food practices among employees and patients. Methods will vary with the hospital, but I will mention a few possibilities.

(Continued on Page 104)

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This all-purpose all-vegetable shortening performs equally well in kitchen or bake shop. You're assured of customer satisfaction at moderate cost.

Kraft Blue Label is a hydrogenated shortening, perfectly balanced for a wide range of uses. It stands up indefinitely in your fry kettles—makes rich, fluffy cakes—light, creamy icings—flaky piecrusts and pastry—crisp rolls.

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THE NATION'S TASTE IS YOUR BEST BUYING GUIDE

(Continued From Page 102)

Some hospitals have a house newspaper for employees or patients or both. One hospital published human interest stories of the food histories of staff members and patients who had been following reducing diets. Patients, physicians and engineers were among those included. The stories were followed with interest by both patients and staff.

The same hospital has a cafeteria for ambulatory patients. Patient education is encouraged by having self-selection of foods in the cafeteria line. A dietitian is available to assist the patients in their selection and, while the patients are eating, she circulates in the dining room to answer questions and discuss diet.

Various visual materials can be used in other dining rooms such as those for employees and physicians. Posters, exhibits and table tents are effective, convenient means of presenting facts about food.

Many patients will receive individual instruction from the dietitian. This instruction can be augmented by visual materials, such as cartoons, poems and jokes placed on the patients' trays. Films offer another way of teaching. One hospital found it possible to assemble small groups of new mothers for a showing of films on development of good food habits in the infant.

Several good pamphlets on normal diet are available free or at low cost and may be placed on trays or used in other ways to answer questions or instruct patients.

The hospital library may include some of the good popular books on nutrition for use of staff and patients, as well as more technical materials for the staff. Such materials should be carefully screened by the dietitian. Cooperation of physician, nurse and dietitian can provide the patient with enough facts about his total diet and adequate understanding of those facts so that he will not be tempted to alter some part of it in accordance with the first item he sees in the newspaper, on television, or hears from a friend.

Among the better books for this use are Leverton's "Food Becomes You," Fleck and Munves' "Modern Diet and Nutrition," and Jolliffe's "Reduce and Stay Reduced."

Employees may be encouraged to bring to the dietitian samples or reports of materials they see or hear. Recently, a cook brought her dietitian some mimeographed material distrib-

uted the previous evening at a P.T.A. meeting. This was brought to my attention because of the misinformation it contained. It was easy to recognize the source, a widely distributed leaflet printed by an organization of extremists. Employees who have children in school can be encouraged to support nutrition education at the elementary and high school levels and to work for a good school lunch program.

The dietitian needs to adopt a questioning attitude and to work through a variety of channels to prevent misinformation and to correct it. Not long ago some questionable statements appeared on two occasions in the publications of an allied professional organization. Letters to the editors brought replies that "no one else objected." Inquiries to others in the field of dietetics and nutrition brought replies that they hadn't read the ads or hadn't noticed the misleading statements.

Perhaps the most important point is to develop in the employees the concept that the best way for the normal healthy individual to be well fed today is to eat a diet composed of a variety of basic foods. Employees should be provided with suitable guides to meal planning and with sources of information about food values, selection and preparation, and food money management. Employees and staff will be much more likely to consult authentic materials if they are readily available than if it is necessary for them to visit the library some distance away or on another floor.

HOW TO EVALUATE INFORMATION

Staff members and employees will also need to be provided with some means of evaluating information received through other channels. This is not easy, but skepticism can be aroused by consideration of the questions that follow.

1. Does the person have something to sell? This may be a vitamin pill, a book, or a newspaper column. In this case the author will use many methods to attract attention. He may present material that is misleading if not entirely contrary to the facts.

2. Does he promise to cure or to prevent disease with food or a food supplement? Along with this often goes the implication that he has information that government agencies do not know or top scientists refuse to accept.

3. What are the training and experience of the author? To what profes-

sional and technical organization does he belong? Here the utmost caution should be used because some popular speakers and writers who deal in misinformation have master's or doctor's degrees from well known universities, while others are in the professions of medicine and dentistry. Perhaps the remark of an eminent biochemist explains this as well as any other. When several of us asked him how one of his former students could be so far from scientific truth, he replied: "This person's information was sound when he studied with me. I don't know how he got into the faddist camp." However, a Yes to the first or second question can act as a further screen.

4. In what nutrition organizations does the individual claim membership? In 1950 the *American Journal of Public Health* listed five organizations in which membership connotes professional standing.

Those listed were: American Board of Nutrition, American Dietetic Association, American Institute of Nutrition, American Public Health Association (fellow, Food and Nutrition Section), and Food and Nutrition Board of the National Research Council. Again, caution must be used because other nutrition organizations have names that are equally impressive and quite similar.

5. Does he advocate or emphasize one food to the exclusion of others, or in other ways depart from the idea of a well rounded diet of a variety of basic foods?

These five criteria taken together will eliminate most of the purveyors of misinformation. The average individual can apply most of them easily and without "looking up anything."

The American Dietetic Association is the professional organization for dietitians and nutritionists. One of its objectives is the collection and publication of authoritative nutrition information. As a result of the concern expressed by members over the prevalence of food misinformation, a special committee was appointed to develop procedures for the use of state and local associations in promotion of authentic nutrition information and correction of misinformation. Objectives of the committee are to correct misleading information by providing technically correct information, and to assist state and local associations in analysis of their food misinformation problems and in plans for positive programs to meet them. (Cont. Page 106)



How can you *perk up their appetites?*

Patients are *people* and the way to the stomach is often as not through the eye, the mood, the spirit!

No matter how good, or how nourishing, or how *right* your food is, it may go untouched if it's served in routine or institutional manner.

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You'll chart a wonderful upturn in appetites, you'll keep costs down and efficiency up when you use Milapaco disposable tray covers.

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Sanitary and speedy: Each tray cover is immaculate to the moment you use it. Of strong, linen-textured paper... no sticking together. Flick them off lightning-quick!



Fit all trays: Both stock and special prints are available in all standard tray sizes.

Samples? Of course... all you need do is fill in and mail the coupon. It will bring you samples and full information on stock and special print tray covers, doilies, and our famous wet-strength Belfast napkins (soft, snowy, and so sterile-pure many hospitals use them for instrument wrapping). We'll include samples and information on portion cups and our wet-strength, almost indestructible bath mats! No obligation, ever!

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(Continued From Page 106)

A tangible result of the interest of A.D.A. members is a new pamphlet published by the association. "Food Facts Talk Back" is a collection of more than 100 food topics on which misinformation is frequently circulated, along with the scientific facts about each topic. This pamphlet will serve as a convenient reference for dietitians and others who frequently encounter food misinformation. (See reference 6 in bibliography following article.)

There are many opportunities for

dietitians, both as individuals and through their association, to influence food habits and nutrition practices. These opportunities may be found in social contacts as well as on the job. Women's clubs and other groups need guidance in selection of programs, films or speakers for club meetings, and persons who prepare advertisements and feature articles for radio, television and press can use suggestions for sources of subject matter.

Dietitians may also, either individually or in groups, cooperate with other professional persons concerned

about nutrition and other aspects of the public health. Through participation in such organized community activities they may help to develop policies in relation to school lunch programs, food allowances for public welfare recipients, and other activities that affect the nutrition of population groups. Dietitians will need to inform themselves about such programs, but they have a good background for doing so and can be of service in interpreting the importance of these programs to others.

SUMMARY

Food misinformation is found among hospital staff members and employees just as it is found among people outside the hospital. It exists because of a lack of understanding of the technical nature of the subject matter of food and nutrition. It is accepted by some persons because they base their beliefs about food and nutrition on emotion rather than on factual information, and by others because of inability to evaluate information in the field. It is voiced by some persons in the paramedical professions as well as by a few physicians and many citizens.

The best way to prevent food misinformation in the hospital is to provide staff and employees with readily available sources of correct information and to utilize all available methods of spreading the facts about food and nutrition.

SUGGESTIONS FOR EMPLOYEES' BOOKSHELF

Composition of Foods—Raw, Processed, Prepared. U.S.D.A. Handbook No. 8. 35c.

Ross, W.: Diet to Suit Yourself. New York: McBride Co., 1954. \$2.50. Also available in a soft cover edition, Signet Key Book. 35c.

Fleck, H. and Munves, E.: Everybody's Book of Modern Diet and Nutrition. New York: Dell Publishing Co., 1955. 35c.

Wishik, S.: Feeding Your Child. New York: Doubleday, 1955. \$3.50.

Levertown, R.: Food Becomes You. Lincoln: University of Nebraska Press, 1952. \$3.50.

Food Facts Talk Back. Chicago: American Dietetic Association, 50c.

Bowes, A. DeP., and Church, C. F.: Food Values of Portions Commonly Used. 8th ed., 1956. \$2.50. Order from A. DeP. Bowes, 7th and Delancey Streets, Philadelphia 6.

Bogert, L. J.: Nutrition and Physical Fitness. Philadelphia: W. B. Saunders, 1954. 6th ed. \$4.50.

Kilander, H.: Nutrition for Health. New York: McGraw-Hill, 1951. \$3.50.

Nutrition Up to Date Up to You. Reprint from Department of Agriculture Home and Garden Bulletin No. 1, 1950. 10c. Order from Supt. of Documents, Washington, D.C.

Jolliffe, N.: Reduce and Stay Reduced. New York: Simon & Schuster Co. Rev. 1957. \$2.95.

IT'S HERE... THE FIRST AND ONLY PRACTICAL IT'S NEW! 3-COMPARTMENT SELF-GENERATING STEAM-COOKER!

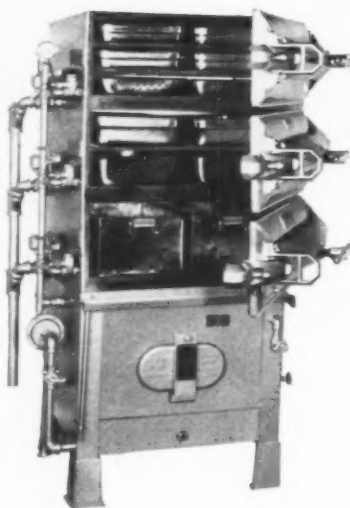
Here it is—the first full-size 3-compartment steam cooker that generates its own steam—the 3SF by STEAM-CHEF!

Without any increase in floor space, here is greater capacity than ever before available in a self-generating steam cooker.

The spacious cooking compartments of the 3SF accommodate up to 18 standard 12 x 20 cafeteria pans, or a combination of these with deep pans, wire baskets, and bake trays. All told, this latest addition to the famous STEAM-CHEF line of "Side-by-Side", high capacity steam cookers can hold up to 6 bushels of food.

The new design of the 3SF steam generating unit provides abundant steam for big cooking or warming jobs in a hurry. The cooker is designed for kitchens serving 700 or more meals an hour.

All three of the cooking compartments are within easy reach. Overall height of the cooker is only 67 inches! Compartments are wider—cafeteria pans fit easily "Side-by-Side". There's no awkward groping for pans-behind-pans. Loading and unloading is easier, faster, safer... so is checking food at any time during the cooking cycle.



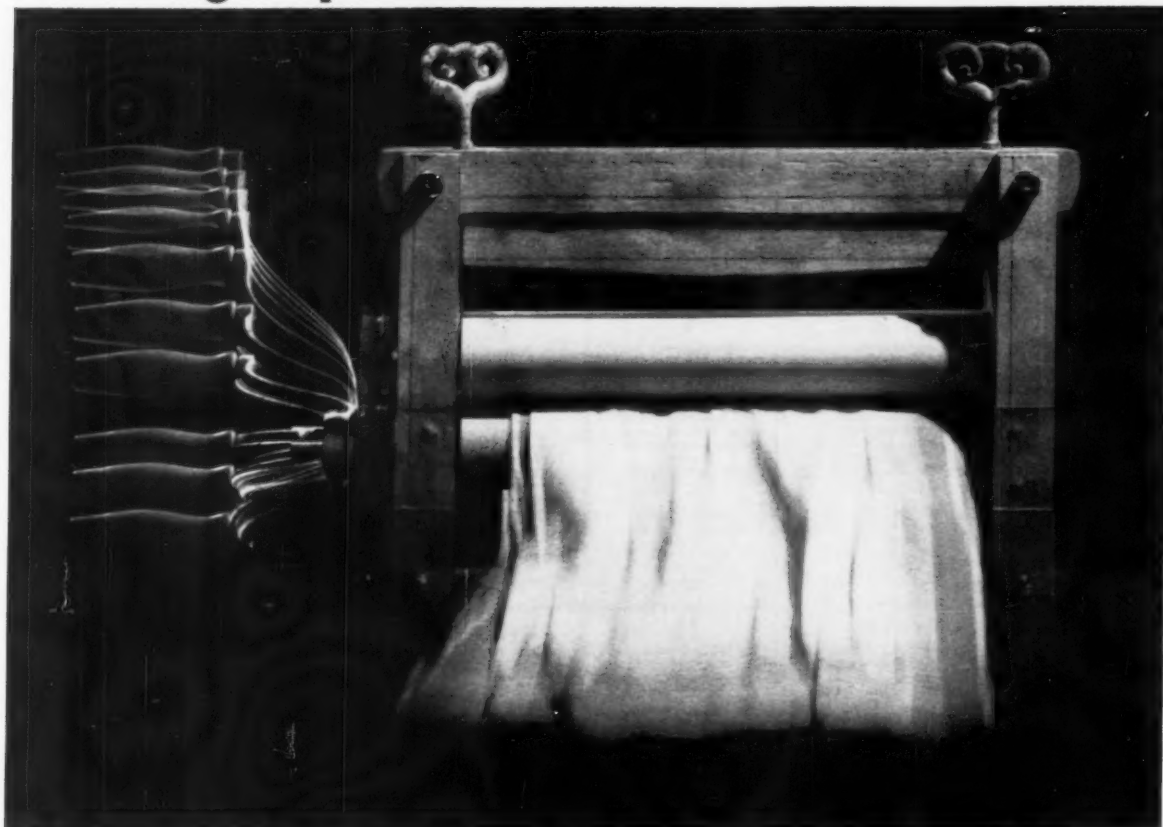
Model 3SF STEAM-CHEF 3-compartment steam cooker. Self generating. Interior: Stainless steel. Exterior: Baked enamel or stainless steel. Height: 67". Floor space: Under 10 square feet. Available for gas or electric operation.

Steam-cooking with Steam-Chef has many other advantages. They're all available in this new Model 3SF. Ask your nearest STEAM-CHEF dealer to demonstrate them to you, or get complete details by writing to:

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Menus for December 1957

Margaret Erickson

Dietitian
Winona General Hospital
Winona, Minn.

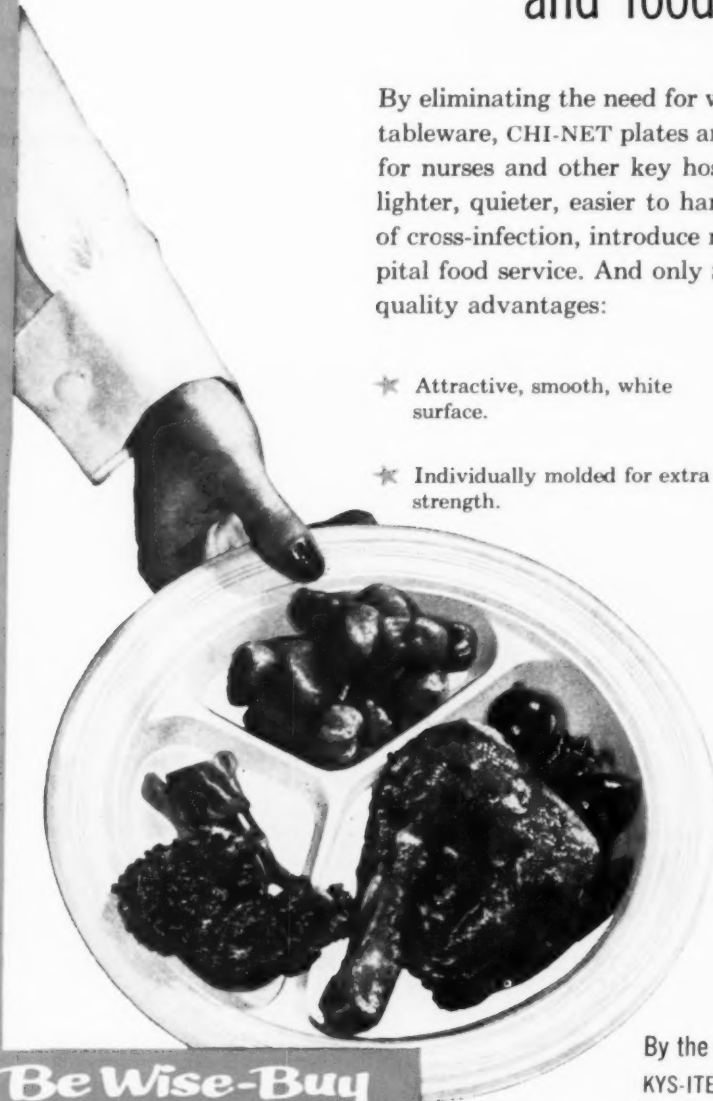
<p>1 Applesauce Soft Cooked Eggs</p> <p>•</p> <p>Swiss Steak Mashed Potatoes Buttered Peas With Onions Tossed Salad Ice Cream, Sugar Cookie</p> <p>•</p> <p>Bean Soup Cheese Rabbit on Rusk Hot Spiced Beets Cabbage-Orange Salad Peach Upside-down Cake</p>	<p>2 Pear Nectar Sausage Links</p> <p>•</p> <p>Meat Loaf, Ketchup Escalloped Potatoes Buttered Asparagus Lettuce Salad, 1000 Island Dressing Apple Charlotte</p> <p>•</p> <p>Cream of Tomato Soup Cold Sliced Meat Potato Salad Buttered Broccoli Pear, Cheese Salad Tapioca Pudding</p>	<p>3 Orange-Grapefruit Juice Poached Eggs</p> <p>•</p> <p>Baked Ham, Horseradish Pittsburgh Potatoes Buttered Spinach Spring Souffle Salad Fruit Cup, Gingersnaps</p> <p>•</p> <p>Barley Broth Baked Sausage Pattie on Pineapple Slice Lemon Buttered Carrots Chef's Salad Parfait Pie</p>	<p>4 Stewed Prunes Bacon Curls</p> <p>•</p> <p>Beef Stew, Biscuits Whole Kernel Corn Pickled Whole Beets Apricot, Cottage Cheese Salad Poppyseed Cake</p> <p>•</p> <p>Vegetable Juice Meat Pattie Mashed Potatoes Brussels Sprouts Carrots, Celery Baked Custard</p>	<p>5 Figs in Sirup Scrambled Eggs</p> <p>•</p> <p>Roast Veal, Dressing, Gravy Oven Browned Potatoes Buttered Lima Beans Waldorf Salad Spanish Cream With Strawberry Topping</p> <p>•</p> <p>Rice Broth Creamed Chipped Beef on Toast Minted Green Peas Citrus Salad Raisin Filled Jumbo Cookies</p>	<p>6 Orange Sections Doughnuts</p> <p>•</p> <p>Poached Haddock, Egg Sauce Baked Potatoes Sweet-Sour Green Beans Green Salad, French Dressing Peach Melba</p> <p>•</p> <p>Clam Chowder Salmon Salad Peach Potatoes Escalloped Tomatoes Stuffed Celery Cherry Coconut Bars</p>
<p>7 Pineapple Juice Soft Cooked Eggs</p> <p>•</p> <p>Braised Liver, Bacon Potatoes au Gratin Creamed Onions Orange, Green Pepper Salad Butterscotch Rolls Plums</p> <p>•</p> <p>Vegetable Soup Frankfurters, Buns Mixed Vegetables Banana Nut Salad Dark Sweet Cherries</p>	<p>8 Tomato Juice Bacon Curls</p> <p>•</p> <p>Fricassee Chicken Mashed Potatoes Buttered Peas Jellied Fruit Salad Pineapple-Cherry Upside-down Cake</p> <p>•</p> <p>Cream of Celery Soup Creamed Potatoes With Bologna Cubes Buttered Spinach Cabbage Slaw Apricots in Sirup</p>	<p>9 Blended Juice Poached Eggs</p> <p>•</p> <p>Roast Beef, Gravy Oven Browned Potatoes Ginger Buttered Carrots Lettuce Salad, Russian Dressing Coffee Ice Cream, Nuts</p> <p>•</p> <p>Noodle Soup Bacon, Lettuce, Tomato Sandwich Potato Chips Fruit Salad Peaches</p>	<p>10 Prune Juice Sweet Rolls</p> <p>•</p> <p>Cube Steaks Creamed Potatoes With Chipped Bacon Escalloped Tomatoes Brussels Sprouts Chocolate Pudding, Whipped Cream</p> <p>•</p> <p>Cream of Potato Soup Macaroni, Tuna Casserole Pickled Beets Sliced Tomatoes on Endive Plums in Sirup</p>	<p>11 Orange Juice Soft Cooked Eggs</p> <p>•</p> <p>Ham Balls With Rice Swiss Spinach Pineapple, Apricot Salad Gingerbread With Whipped Cream</p> <p>•</p> <p>Barley Broth Cold Sliced Meat and Cheese Potato Salad Tossed Salad Sliced Bananas in Cranberry Juice</p>	<p>12 Pineapple Juice Bacon Curls</p> <p>•</p> <p>Corned Beef Parsley Potatoes Seven-Minute Cabbage Peach Salad, Raisin Mayonnaise Filling Lemon Coconut Snow</p> <p>•</p> <p>Cream of Pea Soup Shirred Eggs in Toast Cups Sliced Beets Green Bean-Pimiento Salad Spice Cake With Caramel Frosting</p>
<p>13 Grapefruit Half Scrambled Eggs</p> <p>•</p> <p>Salmon Loaf Creamed Potatoes Hot Spiced Beets Jellied Orange Green Pepper Salad Chocolate Eclairs</p> <p>•</p> <p>Cream of Asparagus Soup Tuna-fish Salad Carrots in Cream Endive Salad, French Dressing Prune Whip With Custard Sauce</p>	<p>14 Apricots in Sirup Soft Cooked Eggs</p> <p>•</p> <p>Breaded Veal Cutlet Baked Potato Julienne Green Beans, Mushroom Sauce Stuffed Prune Salad Ice Cream, Chocolate Chip Cookies</p> <p>•</p> <p>Tomato Bouillon Noodle, Meat, Cashew Casserole Buttered Spinach Apple, Grapefruit, Melon Ball Salad Plums in Sirup</p>	<p>15 Sliced Oranges Shirred Eggs</p> <p>•</p> <p>Baked Ham Candied Sweet Potatoes Harvard Beets Tossed Salad, French Dressing Hungarian Nut Torte</p> <p>•</p> <p>Cream of Potato Soup Hot Beef Sandwich Buttered Wax Beans Cabbage, Pineapple Slaw Fruit Cup, Cookie</p>	<p>16 Assorted Stewed Fruit Soft Cooked Eggs</p> <p>•</p> <p>Salisbury Steak Escalloped Potatoes With Mushrooms Buttered Broccoli Pickled Beet and Egg Salad, Mayonnaise Poppyseed Cake</p> <p>•</p> <p>Chicken Rice Soup Minute Steaks Mashed Potatoes Parsley Carrot Slices Banana-Orange Salad Gelatin With Cream</p>	<p>17 Tomato Juice Sweet Rolls</p> <p>•</p> <p>Chow Mein Chinese Noodles Buttered Broccoli Pickled Beet and Egg Salad, Mayonnaise Poppyseed Cake</p> <p>•</p> <p>Fruit Juice Cocktail Escalloped Potatoes With Ham Carrot, Pickle Sticks Royal Anne Cherries</p>	<p>18 Fresh Pears Sausage Patties</p> <p>•</p> <p>Roast Lamb, Gravy Minted Potato Balls Whole Kernel Corn Citrus Salad, Celery Seed Dressing Chocolate Sundae</p> <p>•</p> <p>Split Pea Soup Cheese Dreams Buttered Asparagus Celery Cabbage, French Dressing Peaches in Sirup</p>
<p>19 Apple Juice Scrambled Eggs</p> <p>•</p> <p>Spanish Steak Mashed Potatoes Buttered Wax Beans Cabbage, Grape Salad French Apple Pie, Cheese Topping</p> <p>•</p> <p>Noodle Soup Vegetable Plate With Hot Stuffed Egg Bran Muffins Tomato, Lettuce Salad, Mayonnaise Plums in Sirup</p>	<p>20 Stewed Spice Prunes Coffee Cake</p> <p>•</p> <p>Walleye Pike, Tartare Sauce Macaroni and Cheese Escalloped Tomatoes Chef's Salad Lemon Meringue Pudding</p> <p>•</p> <p>Cream of Celery and Mushroom Soup Tuna-fish Pie Baked Potato Buttered Asparagus Pineapple, Cottage Cheese Salad Custard</p>	<p>21 Cranberry Nectar Soft Cooked Eggs</p> <p>•</p> <p>Roast Veal, Dressing Oven Browned Potatoes Lyonnise Potatoes Diced Rutabagas Spiced Apple Salad Cherry Shortcake, Whipped Cream</p> <p>•</p> <p>Cream of Tomato Soup Ham Salad Sandwich Plate Potato Chips Peas in Cream Celery Cabbage, Cheese Dressing Chocolate Pudding With Cream</p>	<p>22 Apricots With Lemon Bacon Curls</p> <p>•</p> <p>Baked Pork Chops Escalloped Potatoes Diced Rutabagas Carrots in Cream Tomato, Endive Salad Ice Cream With Lemon Wafers</p> <p>•</p> <p>Barley Broth Hamburgers, Buns, Relishes Asparagus Tips Fruit Salad Apple Betty With Cream</p>	<p>23 Grapefruit Juice Poached Eggs</p> <p>•</p> <p>Swedish Meat Balls Mashed Potatoes Diced Rutabagas Waldorf Salad Chocolate Angel Food Cake</p> <p>•</p> <p>Cream of Potato Soup Cheese Souffle With Bacon Baked Potato Escalloped Tomatoes Asparagus, Pimiento Salad Fruit Cup</p>	<p>24 Boysenberries Sweet Rolls</p> <p>•</p> <p>Roast Beef, Gravy Riced Potatoes Buttered Sliced Beets Jellied Spiced Peach Salad Glorified Rice</p> <p>•</p> <p>Tomato Bouillon Creamed Eggs and Chipped Beef on Cornbread Buttered Peas Pear, Melon, Cherry Salad Spice Cake</p>
<p>25 Broiled Grapefruit Half Baked French Toast</p> <p>•</p> <p>Cherry Juice Cocktail Roast Turkey, Dressing Giblet Gravy Mashed Potatoes Mixed Vegetables Jellied Cranberry Salad Ice Cream, Christmas Cookies</p> <p>•</p> <p>Oyster Stew, Cheese Crackers 24 Hour Fruit Salad Pumpkin Pie</p>	<p>26 Pineapple Juice Soft Cooked Eggs</p> <p>•</p> <p>Baked Ham, Raisin Sauce Escalloped Potatoes Buttered Carrots Lettuce Salad, 1000 Island Dressing Apricot Crisp, Cream</p> <p>•</p> <p>Tomato Bouillon Baked Hash With Poached Egg Buttered Beets Vegetable Relishes Fruit Ambrosia</p>	<p>27 Tomato Juice Scrambled Eggs</p> <p>•</p> <p>Halibut Steaks, Lemon Sauce Escalloped Potatoes Buttered Peas, Celery and Cucumber Relish Raspberry Bavarian Cream</p> <p>•</p> <p>Cream of Corn Soup Chinese Omelet, Mushroom Sauce Buttered Broccoli Peach, Cottage Cheese Salad Vanilla Pudding, Cream</p>	<p>28 Nectarines Doughnuts</p> <p>•</p> <p>Meat Pie, Biscuits Parsnips With Orange Glaze Apricot-Date Salad Steamed Cranberry Pudding, Vanilla Sauce</p> <p>•</p> <p>Beef Broth Tuna-fish Salad Raisin Bran Muffins Buttered Carrots Spiced Apples Dark Sweet Cherries</p>	<p>29 Citrus Sections Shirred Eggs</p> <p>•</p> <p>Veal Birds, Gravy Mashed Potatoes Buttered Squash Golden Glow Salad Lemon Sherbet, Cupcake</p> <p>•</p> <p>Cream of Tomato Soup Meat Croquettes, Celery Sauce Julienne Green Beans With Almonds Date Waldorf Salad Banana Cream Pie</p>	<p>30 Stewed Prunes Bacon Curls</p> <p>•</p> <p>Sauerkraut, Gravy Hashed Brown Potatoes Buttered Cauliflower Pickled Beet and Egg Salad Angel Food, Strawberry Topping</p> <p>•</p> <p>Vegetable Juice Chop Suet Chinese Noodles Pineapple, Apricot Salad Blueberry Pudding</p>
<p>31 Tomato Juice, Soft Cooked Eggs • Braised Liver, Bacon, Baked Potato, Buttered Peas, Green Salad, French Dressing, Chocolate Pudding, • Vegetable Soup, Creamed Chipped Beef on Toast, Relish Plate, Poppyseed Cake. Ready-to-eat or cooked cereals served on all breakfast menus.</p>					

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MAINTENANCE AND OPERATION

How to Recognize a Good Maintenance Man

Even though he doesn't know all the technical aspects of the engineering department, the administrator must know enough about its principles and operation to be able to evaluate the competence of the person he employs to run it

GEORGE E. LINNEY

ONLY within recent years has hospital management recognized the fact that the engineer, maintenance supervisor, or maintenance superintendent—whatever his title—plays an important part in an organization designed to give medical and surgical care to the sick and injured.

Application of the latest mechanical and electrical features and the introduction of many of the principles of electronics into diagnostic and therapeutic equipment, as well as into general equipment such as heating, ventilating, transportation and communication, have made it imperative that engineering and maintenance problems not be neglected or overlooked.

Much of the equipment used by a hospital, like its personnel, is subjected to rigorous, 24 hour service. General utilities such as heat, light and hot water must be provided continuously. Breakdowns are bound to occur, but many can be prevented or at least delayed by adopting a workable preventive maintenance program.

In this age of specialization, the general handyman has been replaced in hospital maintenance work by the trained maintenance supervisor who is thoroughly familiar with the equipment, who appreciates the tremendous investment it represents, and who makes an intelligent effort to get uninterrupted and efficient performance from it.

Administrators of small hospitals

Mr. Linney is administrator of Griffin-Spaulding County Hospital, Griffin, Ga. At the time this paper was prepared, he was administrator of Americus and Sumter County Hospital, Americus, Ga.

may not be fortunate enough to be able to employ full-time trained engineers. Therefore, they themselves must know something of the principles and functions of the major items of equipment in their hospitals. Often the administrator must be the repairman.

The administrator of a larger hospital, while he need not be a specialist in the technical aspects of the equipment, must know enough about its principles and operation so that he can at least appraise the service of the engineering department. Certainly, he should be able to evaluate the competence of the man he places in charge of the department. In a large hospital the chief of maintenance may be given the title of assistant administrator, and as such he may be responsible for several other departments, including laundry and housekeeping. In any event, the administrator of a modern hospital must keep in touch as closely with the mechanical and electrical equipment of his institution as he does with the members of his medical staff and governing board.

DOES THE ENGINEER QUALIFY?

Now let us look to the engineer's qualifications. Suppose you are an administrator seeking to employ an engineer or maintenance supervisor. What qualifications should you look for?

First, I think the engineer should have some hospital or hotel experience. The larger hospitals would do well to consider a graduate engineer. The smaller hospital need not require such an educational background but should investigate the man's experience.

The applicant should have a good

working knowledge of steam systems, and he should have some understanding of electrical equipment, including motors and switch gear. He should know something about plumbing, with experience in fitting and replacing pipes, repairing valves and fittings, and keeping such systems clean and free from obstructions. Local ordinances may require that he be licensed to perform his duties. This often is the case when steam and high-pressure equipment is involved. It is necessary that the man can comply with local requirements such as these.

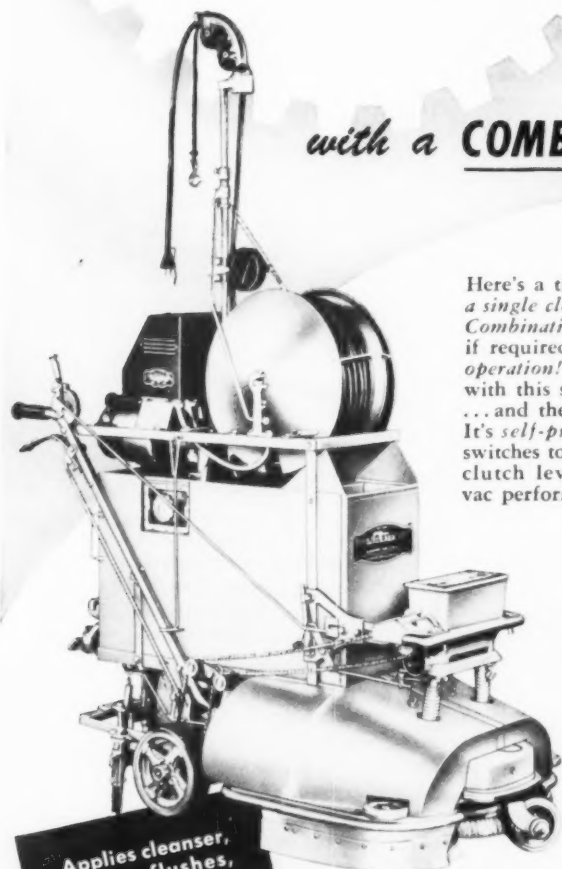
Today's modern machinery depends to a great degree on lubrication, and the maintenance man should have a knowledge of lubricants and their most effective and efficient use. Often it is just as dangerous to oil or grease a machine too much as it is to neglect to lubricate it. Lubricants are important in keeping plant equipment running and in cutting down operating costs and repair bills.

Consider yourself most fortunate if your prospective maintenance supervisor or engineer has a working knowledge of electronics, intercommunication systems, elevators and other transportation systems, and x-ray equipment. Often it is advisable for the administrator of a small hospital to farm out the maintenance of this highly specialized equipment through service contracts that provide for periodic checkups.

The engineer must possess honesty and integrity. I remember a college professor of mine saying many times that engineering is an exact science. There is no guesswork. There is no "maybe." The answer must be Yes or

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No, right or wrong. He was not a moralist, he was just stating facts. I would much rather have an engineer say he did not know what to do about a particular breakdown than for him to try to bluff his way through. There is too much at stake for that type of attitude. An engineer who says: "I don't know, but I can get someone who does" is worth more than one who stalls and, in blind ignorance, tries to repair complicated equipment with which he has had little, if any, experience.

Recently *Plant* magazine listed 10 qualifications or characteristics of a good maintenance man. Among them is a calm, easy disposition. The supervisor must not get ruffled when things go wrong, and he must show a genuine interest in what he is doing. I would add that he is akin to the administrator in that he must have a set of nerves steady enough to face almost any problem.

He should be a man who has become somewhat "settled in his ways," so that he does not accept the latest gadgets without thorough investigation, and yet he should be open-minded enough to be receptive to new ideas and improved procedures. He must be conscious of the fact that technics, tools and materials are being improved continually to help him do a more efficient job.

I have said before that the administrator must have a general knowledge and appreciation of the variety of equipment in his institution. The engineer, on the other hand, must have a detailed working knowledge of this equipment to meet any emergency that may arise. He must be painstaking and careful, appreciating the value of attention to small things.

A good maintenance man should have a natural desire to read and study technical publications, as well as maintenance and repair manuals. The man who throws aside such literature marks himself as one who "knows all about it" without requiring any outside help. This is a dangerous attitude.

Let's go back for a moment to my college professor friend. He used to caution us that the ability to explain things clearly to others was an evidence that we knew the subject ourselves. An engineer supervising the work of those under him should at least try to develop this ability if he does not come by it naturally.

A maintenance man who is clean in his personal appearance is more likely

to keep his machinery and the spaces around it clean and orderly. It is easier to spot something out of order when a machine is clean, free from dust and from an accumulation of lubrication or waste matter. The hospital engineer need not assume the appearance of a grease monkey, even though his job may demand that he get his hands dirty frequently.

Good equipment can deteriorate long before its time as a result of gross neglect on the part of the engineer. The engineer should be on his toes, making routine inspections and taking steps necessary to prevent breakdowns. Too often repair is considered maintenance, and under this misnomer relatively nothing is done until trouble develops or a breakdown occurs. Sometimes even then just enough is done to restore the equipment to poor or inefficient working order. Repair is only one phase of maintenance, and certainly an effective maintenance program can minimize repairs.

It might be well to mention here that hospital equipment, particularly that which deals directly with diagnosis and therapeutic care of the patient, often becomes obsolete long before completion of its normal life span. Sometimes costly repairs are not justified. Too much money can be spent on repairing a piece of equipment when it might be more economical to buy a new unit. It is, of course, important that all equipment be taken care of through regular inspection and correction of any faults.

SAVES MONEY FOR HOSPITAL

A good maintenance man can truly be an administrator's right arm, and he is one of the most important men on the hospital payroll. He can save the hospital many hundreds of dollars in the proper administration of his department. He is as much an "on-call" employe as any member of the staff. Perhaps he is even more so, because so much hospital equipment must function on a 24 hour basis.

In the average-size hospital it often is necessary for a man to develop more than one major skill. For instance, a painter can usually learn to do plastering, at least patching, and sometimes simple masonry. Steam-fitting and plumbing are not as far apart, at least not in hospital work, as the highly specialized trades would have us believe. Even a carpenter can develop into a furniture repairman and add upholstery as a sideline.

In saying all this I am not unmindful of the fact that in the smallest hospitals the steam-fitter, plumber, painter, plasterer, carpenter and furniture repairman sometimes cannot be found in one man. Often it is the administrator who has to do these jobs.

A new idea in maintenance should appeal to groups of smaller hospitals in the same area. This is the "circuit rider" type of maintenance man who travels to two, three or more small institutions, spending perhaps a day or two a week at each. During this time he checks equipment and makes necessary small repairs. Hospitals not financially able to hire a full-time man could benefit from this service.

I would not say that the foregoing is the most desirable or the best plan, but it is far better than no help at all for institutions that must wait until a breakdown occurs and then call in a repairman at a handsome price. Circuit riding maintenance men could handle several small institutions, and the contribution of each to his salary would not be prohibitive, and yet would give him an adequate income.

The hospital administrator increasingly is faced with the question, "How much of my maintenance activity should I farm out by contract?" Most manufacturers of major equipment now offer attractive contracts for maintenance of their equipment; these are available for sterilizers, elevators, x-ray equipment, refrigeration systems, air conditioning systems, sprinklers and fire alarms, and communication systems.

For a hospital to have on its payroll an engineer experienced in all of these activities is most unusual. Generally, these maintenance jobs require specialized personnel. However, the hospital engineer should consider every reasonable way to do specialized maintenance himself or with his own staff. It is well carefully to compare the cost of this method against the cost of a maintenance contract, not forgetting that in the maintenance contract payment is made for some on-call service that may not be needed.

Sometimes the contract is written to include routine periodic inspections, with additional charges for materials and on-call service.

Larger hospitals find that specialized maintenance can be more advantageously handled through personnel available on their own payrolls. Smaller hospitals, on the other hand, find it is better to contract for these services.

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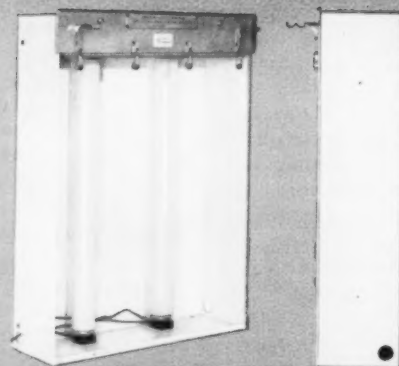


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A Training Program for Housekeepers

9. Technic for Disposing of Isolation Linen

BARBARA D. MILLS

EVERY hospital must establish precautionary measures to handle types of illness that should be "isolated," or kept apart, from other activities in the hospital. These isolation technics are *as strong as your weakest link*. Too often the weakness starts with assembling the equipment with which to set up this technic.

WHERE PRECAUTIONS START

For example, at 10:30 p.m. a communicable disease patient arrives. Where does nursing start to establish precautionary measures? Well, it goes something like this: Equipment such as gowns, masks, gloves (if required), and isolation laundry bags is necessary. If it is not available, the nurse has no alternative but to rush from floor to floor for the equipment. It is my contention that nursing skills should not be misused in this fashion. Nurses have more important duties to perform than running about to gather supplies of this nature.

Therefore, the responsibility for assembling these various items should be planned as a definite procedure, and the responsibility for establishing a "starter setup" delegated elsewhere than the nursing floor. In most instances the "elsewhere" means the housekeeping department. This I would accept, for we are the part of the team closest to all these various

needs, as well as handling disposal, daily cleaning of patient areas, and all terminal cleaning.

Paint a No. 2 galvanized garbage can white, with a square of color associated with precaution, such as red, blue or green. Number the cans 1, 2 and 3, and so on. St. Luke's Hospital, Chicago, uses dark green equipment for all disposal that requires special handling, so no other markings are necessary. I have found that using the simplest means to denote precaution among those who need to know is much better than screaming it from the housetops for all to notice.

SERVES AS LINEN HAMPER

This disposal can will serve as a closed linen hamper during the isolation period. So that it can be moved easily, the can should be mounted on a regular metal milk can dolly with three swivel wheels. This dolly may be purchased at a nominal cost, but it is also possible to have one made of wood by a carpenter. It will serve the same purpose but requires more effort and time to clean, because the wood must be thoroughly dry before it is put back into service.

Rigid precautionary technics are fast becoming a thing of the past as a result of the numerous antibiotics. Today, as you have seen, precautionary technics can prevail in an open ward. The best way to establish procedures for infectious and communicable diseases is to check with the state board of health and be guided accordingly—if, of course, the hospital's administration concurs. In some instances the

administration may have a more rigid outline of procedures.

There is a difference between infectious and communicable diseases. An infectious disease is caused by a pathogenic organism, which may or may not be communicable. Anything that is *communicable* is transmissible by *contact*. The organism may be air-borne or carried by direct contact from one individual to another. Some respiratory diseases that are transmitted by direct contact are diphtheria, scarlet fever, influenza and pneumonia. Some diseases that are spore-borne and bacteria forming are gas gangrene and tetanus.

The following items make up an isolation "starter set" and should be placed within the can:

- 2 Gowns
- 6 Masks
- 1 Wastebasket
- 2 Isolation bag liners
- 6 Wastepaper bags
- 1 Pair rubber gloves
- 1 Nail brush
- 2 Sputum cups

LINERS MADE OF TWILL

All are standard equipment, with the exception of the liners. These are made of green twill or cubicle curtain material to fit the cans. Eight grommets are put in the top band for the pull cord, or you can just put the cord through a double heading. No marking is used; color coding establishes treatment in the laundry.

After the equipment is put into use a green liner is placed inside the can to receive the soiled linens. The top

At the time this series was prepared Mrs. Mills was director of housekeeping services, St. Luke's Hospital, Chicago. She is now director of housekeeping services, Allegheny General Hospital, Pittsburgh. This is the ninth in the series.

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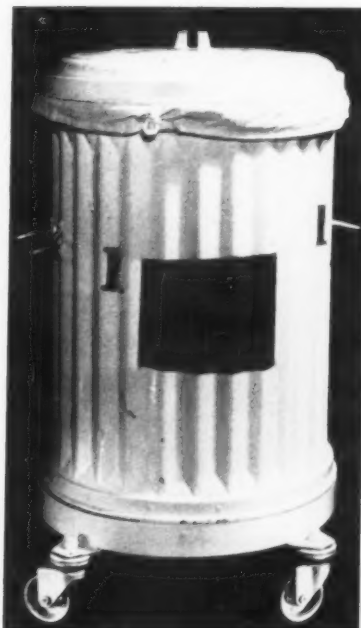
must be kept on. I believe you will find this pattern of supplying isolation equipment one of the easiest and most efficient methods there is.

Lines of communication should be established as follows:

1. Nursing informs housekeeping department of location and time of need.

2. An isolation can, already set up, is rolled to area needed by houseman. (Number of can with date and location is posted on board in housekeeping supply or storage room.)

3. When patient is discharged, nursing advises housekeeping; the iso-



Isolation linen can used at St. Luke's Hospital is mounted on wheeled dolly.

lation linen can, wastebasket and a nail brush are returned to housekeeping department supply or storage room after the patient's room has been aired 24 hours. (Number of can is posted on the board, and now the return date is posted after the outgoing date.) After being thoroughly cleaned or autoclaved, this particular can is set up and made ready to go again.

Isolation linen liners are to be ordered on floor linen requisitions. The nursing floor is responsible for all equipment except the first supply or starter set. When liners are full of soiled linen the nurse can roll the isolation can to the linen chute and dispose of the full liner. She then gets replacements from the floor linen room.

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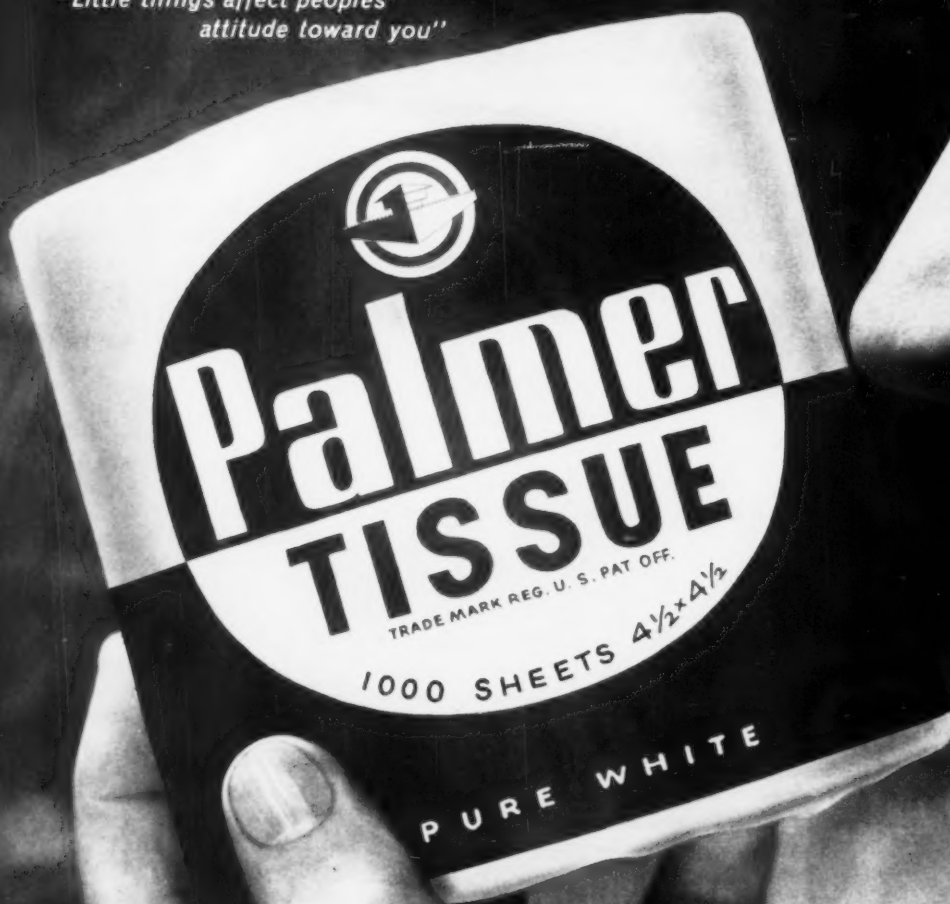
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NEWS DIGEST

Panel Stresses Radiation Dangers During Childbearing Years . . . Proposed Rate Increase for Philadelphia Blue Cross Is Criticized . . . Michigan Doctors Approve New Blue Shield Outpatient Benefits . . . Pharmacists Elect Two New Officers

Radiation Danger Highest During Childbearing Years, Roentgen Ray Society Panel Emphasizes

WASHINGTON, D.C.—It is not the radiation received by any one individual that is most important, but the average received by the entire part of the population between conception and the end of childbearing that must concern the radiologist, a panel of scientists here concluded recently.

The panel opened the 58th annual meeting of the American Roentgen Ray Society attended by nearly 2000 of the nation's radiologists October 1 to 4.

That the mutation problem is one for concern was pointed out by Dr. Bentley Glass, biologist of Johns Hopkins University, Baltimore, who said that a 10 per cent increase in the number of tangible genetic defects could be predicted.

Hope for improvement of this dire prediction was offered, however, by other members of the panel who noted that many safeguards are available to cut down the current gonadal dose being received by Americans under 30 years of age.

Seven papers on "Radiation Hazards and What Is Being Done About Them" were given at the panel meeting.

Life shortening for workers necessarily exposed every day to very small doses of medical and industrial radiation is considerably less than some recent, widely quoted discussion has indicated, Dr. Gioacchino Failla of New York told the panel. "In fact," he said, "there is convincing proof that actually radiologists may have a slightly longer life span than physicians as a whole."

"Most mutations may be expected not to result in conspicuous abnormalities but to be manifested simply as an increase in the present types of abnormalities," Dr. Glass said in leading to his conclusions. "There is no sign of a threshold dose below which mutations are not produced," he added.

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to obtain the smallest field size necessary; heavy filtration and/or high voltage; scrotum shields or pelvic girdles; fast film and optimum developing chemicals and temperatures, and image intensification where feasible will result in a significant reduction in the patient's exposure to medical x-rays, said Dr. John S. Laughlin, radiation physicist associated with New York City's Memorial Center.

"Most advice necessary for minimum radiation exposure in medical diagnosis has been available for years," Lauriston S. Taylor, chief of atomic and radiation physics in the National Bureau of Standards, told the panel. He listed: periodic testing of the x-ray machine, use of more efficient higher kilovoltage, care in film development to avoid needless repeat studies, proper use of the fluoroscope, dark adaptation of eyes for 20 minutes before fluoroscopy, and installation of the proper shutters.

"If reduction in life span is proportional to the dose of radiation received,"

(Continued on Page 132)

Hospital Pharmacists Name Two New Officers

WASHINGTON, D.C. — Robert C. Bogash, chief pharmacist at Lenox Hill Hospital, New York, has been named president-elect of the American Society of Hospital Pharmacists. Clifton J. Latiolais is the new vice president-elect. Mr. Latiolais is assistant director of the audit of pharmaceutical service in hospitals, which is being carried out through the division of hospital pharmacy of the American Pharmaceutical Association and the American Society of Hospital Pharmacists.

Mr. Bogash and Mr. Latiolais will be installed during the society's annual meeting, to be held in Los Angeles in April.

Insurance Commissioner Orders Hearings in Blue Cross Rate Controversy

PHILADELPHIA. — Investigation by the city, state insurance commission hearings, a controversy with the county medical society, and widespread publicity followed announcement here last month that Blue Cross would seek rate increases amounting to 40 per cent in some cases and as much as 70 per cent for some groups.

E. A. vanSteenwyk, executive vice president of Blue Cross, said the proposed rate increases were made necessary by rising hospital costs and increasing utilization of hospitals by subscribers. The increase had been under study for 10 months, he added.

In a widely publicized statement, State Insurance Commissioner Francis R. Smith said Blue Cross would "have to account for every nickel" to support the rate increases in public hearings ordered by the commissioner.

All data submitted by Blue Cross will be open to all interested parties, and to the public, Commissioner Smith said.

When the hearings take place, a representative of the city government of Philadelphia will be on hand "in the interests of the general public," Mayor Richardson Dilworth explained. The mayor ordered city intervention in the rate dispute because more than 7000 city employees are enrolled in Blue Cross, he said.

"The city desires to explore fully and fairly all the circumstances surrounding the proposed increase," Mayor Dilworth declared. "If any increase is warranted after we learn all the facts, the city will not oppose an increase as such."

"However, I have asked City Solicitor David Berger to make a full and complete examination of the operations of Blue Cross, including actual costs, methods of auditing, and the manner in which Blue Cross reimburses hospitals for services performed."

(Cont. on Page 134)

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Michigan State Medical Society Approves Increased Blue Shield Outpatient Benefits

GRAND RAPIDS, MICH.—The first major alteration in Michigan Blue Shield in nearly 17 years was adopted by the Michigan State Medical Society's house of delegates at its meeting here September 25, following a report of a statewide survey of public opinion concerning health insurance coverage.

Included were broader benefits for subscribers, including surgery in doctors' offices; diagnostic and therapeutic radiology in the hospital, the out-

patient department, or the doctor's office, and diagnostic laboratory work in the hospital outpatient department private laboratory, or doctor's office.

According to the *New York Times*, the new program is expected to go into effect early next year.

Also outlined, according to an October 14 report of the American Medical Association, were a deductible and co-insurance type of contract, providing full payment for some services

and partial payment for others, an increased income-limit clause so that Blue Shield will cover the major costs for families up to \$7500 of annual income; adoption of a series of unit values for various phases of medical care, including work by the family doctor, diagnosis, x-rays, surgery and all other treatment; endorsement of other insurers who want to set up the same type of coverage as Blue Shield, provided they live up to specified criteria.

Among other benefits mentioned were all complications of obstetrical care and payment to physicians, consultants and surgical assistants in the hospital. Optional for future consideration would be payments for office or home calls by doctors, prescriptions, physical therapy, and artificial limbs.

Results of the public opinion survey, which elicited some 12,000 replies, indicated that diagnostic service in hospitals was the additional benefit most desired. Others included x-rays, emergency house calls, vaccinations, surgery in doctors' offices, and medical consultations.

The five-month survey, conducted by the state medical society and the Michigan Health Council, involved 1000 personal interviews and 60,000 questionnaires mailed to Michigan residents.

The same questionnaire also was reprinted in two Michigan newspapers. In addition, a separate survey of doctor opinion and a compilation of facts from other surveys on the subject were included.

Of the 81 per cent of Michigan residents covered by health insurance, 64.6 per cent have Blue Shield coverage. Of these, 64 per cent like the service, 26 per cent were noncommittal, and 10 per cent expressed an unfavorable opinion, according to the A.M.A. report.

The survey showed that the average payment for Blue Shield medical and surgical coverage is \$2.83 per month. The majority of subscribers are willing to pay up to \$6.95 per month to obtain additional benefits, according to the report.

The respondents were divided almost evenly for and against on the question of deductible medical-surgical cost payment. The majority of those in favor of such coverage voted for \$25 deductible rather than \$50 or \$100. Dr. George Slagle, president of the medical society, said, in a discussion of the survey before the house

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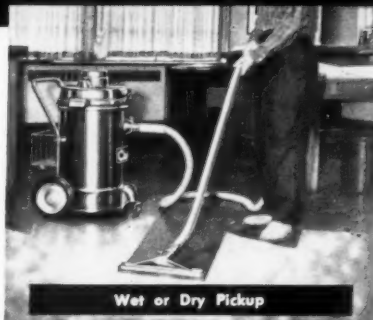
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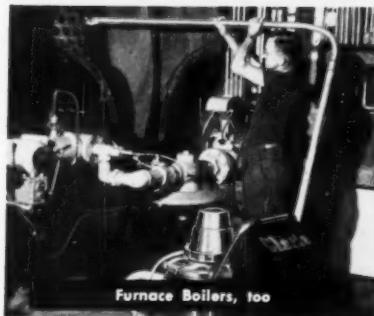
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of delegates, that the survey indicated there would be "definite public acceptance" if a deductible plan were introduced.

The doctors specified that the responsibility of the subscriber under such a plan should be not less than 10 per cent, or \$5, whichever is more, but not more than the scheduled fee allowance, according to the *New York Times* report.

Under the program approved by the medical society, the limit of patient participation per year is \$25 for those with basic incomes under

\$2500; \$50 for those with incomes between \$2500 and \$5000, and \$75 for those with incomes between \$5000 and \$7500. The fee for subscribers with incomes above \$7500 would be the result of agreement between patient and physician, the *Times* report said.

Extension of outpatient benefits under Michigan Blue Cross-Blue Shield was announced in July by the insurance plans. These benefits included all surgery performed in hospital outpatient departments or doctors' offices. An over-all average increase of 12

per cent in Michigan Blue Cross-Blue Shield rates also was approved in July by State Insurance Commissioner Joseph A. Navarre. At that time it was announced that the new rates and benefits would become effective in October.

Number of Internships Offered Up 31 per Cent in 10 Years, A.M.A. Says

CHICAGO.—The number of hospitals approved for intern training has increased 6 per cent in the last 10 years, and the number of internships offered has risen 31 per cent in the same period, the American Medical Association reported last month, in its annual report on internships and residencies.

The number of interns per hospital has increased from 11.3, 10 years ago, to 13.9 in 1956-57.

Federal hospitals offered 5.4 per cent of the internships available, while nonfederal governmental hospitals offered 32 per cent, and nongovernmental hospitals the remainder. The federal hospitals had the highest rate of filled positions, with army hospitals having no vacancies and Public Health Service hospitals having 99 per cent filled. County and state hospitals had occupancy rates of 91 and 89 per cent respectively.

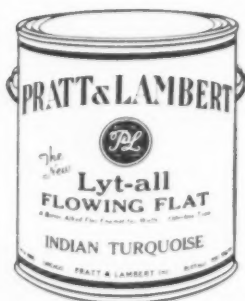
According to the report, prepared by the association's council on medical education and hospitals, there has been an increase in the average monthly cash stipend paid to interns. Hospitals affiliated with teaching institutions raised their stipends from an average of \$87 per month in 1954 to \$140 in 1956. Nonaffiliated hospitals raised their payments from an average of \$136 per month to \$177.

Among residencies, seven specialties accounted for more than three-fourths of all approved residencies, the report said. These were surgery, internal medicine, pathology, obstetrics-gynecology, radiology, psychiatry and pediatrics.

There were 9893 graduates serving internships in 1956-57, an increase of 290 over 1955-56, while 23,012 were serving residencies, an increase of 1587 over the preceding year, the report said. This training was offered by 1372 approved hospitals.

The percentage of available internship and residency positions filled in 1956-57 remained the same as that of 1955-56. Respectively, they were 83 and 81 per cent filled.

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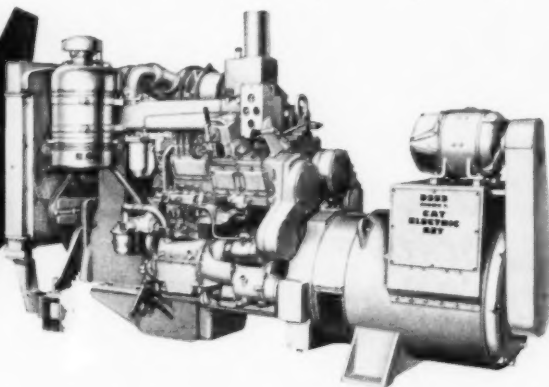
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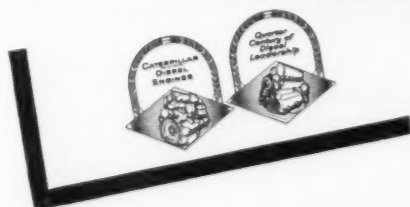
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Pathologists Cite Need for Better Salaries for Medical Technologists

NEW ORLEANS. — One of every three hospital laboratory benches either is empty or is occupied by an inadequately trained technician, Dr. William O. Russell, chairman of the National Committee for Careers in Medical Technology, told members of the American Society of Clinical Pathologists and the College of American Pathologists at their joint meeting here last month.

Dr. Russell explained that the figures were based on a recent survey in a semi-industrial area, and that the situation probably was worse in many rural areas where hospital laboratory facilities were even less adequate.

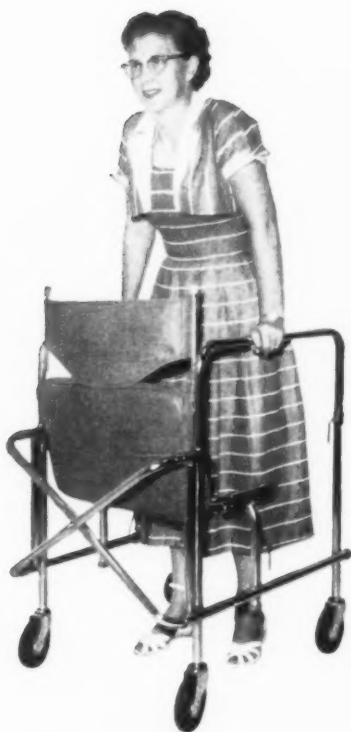
During the last three years there has been a 22 per cent increase in the number of medical technology students enrolled in schools approved for training by the American Medical As-



Dr. Charles Larson (l.) of Tacoma, Wash., new president of the College of American Pathologists, congratulates Dr. Frank Coleman of Des Moines, Iowa, on his election as vice president.

sociation, bringing the total number of students in these schools to nearly 3000, he said. However, of the 24,274 medical technologists certified as fully trained by the American Society of Clinical Pathologists and registered at the Board of Registry of Medical Technologists, only about 18,000 are working, Dr. Russell noted.

Also speaking during the panel meeting on medical technologist recruitment and training was Dr. Henry Wollenweber, who pointed to salaries as being a crucial factor, citing 1956-57 Department of Labor statistics for 10 cities. He stressed the fact that, while the averages were based on the earnings of registered medical technologists or their equivalent, they did not include supervisory personnel,



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and, they were for women only. The highest salaries, he noted, were paid in cities where educational requirements are maximal: Los Angeles, \$83.50 per week; San Francisco, \$80.50; Minneapolis, \$79. Other cities listed were Chicago, \$71; Memphis, \$69; Dallas, Tex., \$68.50; St. Louis, \$66; New York, \$65; Boston, \$60, and Philadelphia, \$57.

Dr. Wollenweber compared the 10 city average of \$69.95 for medical technologists with other hospital professionals, including the medical social worker, who receives \$84.31; the

medical record librarian at \$78.25; the physical therapist at \$76.35, and the x-ray technician at \$65.45. As against these, he pointed out that the technical stenographer, requiring no college education but most often having from six months to a year of post-high school training, receives \$63.88. This is only \$6 less per week than the medical technologist receives, and she must have at least three years training after high school, Dr. Wollenweber said.

Dr. Charles P. Larson of Tacoma, Wash., took office as president of the

College of American Pathologists. Dr. Frank C. Coleman of Des Moines, Iowa, was elected vice president. Chosen for the board of governors were Dr. A. Reynolds Crane, Philadelphia; Dr. Gretchen Squires, Pensacola, Fla.; Dr. Frank B. Queen, Portland, Ore., and Dr. Louis S. Smith, Dallas, Tex.

Dr. Harry P. Smith, professor of pathology at Columbia University, was installed as president of the American Society of Clinical Pathologists. Dr. Edward L. Burns of Toledo, Ohio, was named president-elect. Other newly elected officers are vice president, Dr. Joe M. Blumberg, Washington, D.C.; and executive committeemen, Dr. Jeff Minckler of Portland, Ore., and Dr. Harold D. Palmer of Denver.

The Ward Burdick Award, given each year for outstanding service in the field of pathology, was presented at the annual banquet to Dr. Harold L. Stewart, chief, pathologic anatomy branch, Clinical Center, National Institutes of Health, Washington, D.C., and chief of pathology for the National Cancer Institute.

A certificate of merit was awarded by the American Society of Clinical Pathologists to Dr. James B. McNaught of Denver for eminence in the profession. It was the fifth such award in the society's history.

A feature of the banquet was the first showing of "The Human Cell and the Cyto-Technologist," the second in a series of recruitment films on medical technology. The film was sponsored by the pathology societies and the American Society of Medical Technologists.

A simple blood test for early detection of clotting tendencies in the blood that lead to heart attacks and strokes was cited as a distinct possibility by a team of three Chicago medical scientists in a paper delivered before the two pathology groups.

Possibility of such early detection grew out of a study of fats and their influence on the clotting mechanism and the liver function of both healthy and sick persons. The study was made by Drs. Emanuel E. Mandel, Anne U. Barnes, and Frederick W. Preston, of Mount Sinai Hospital, Veterans Administration Research Hospital, and Northwestern University, Chicago.

The two groups of pathologists met for lectures, workshops and panel discussions during the week-long gathering. It was the 36th annual session of the society and the 11th yearly meeting of the college.

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NEW YORK.—The recently adopted code of ethical standards of the Health Insurance Association of America has been produced in leaflet form, it was announced last month.

Acceptance of the nine points of the code has been made a condition of membership in the association. Each member is pledged to the following:

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5. Engage only in sales methods, promotional practices, and other transactions which give primary consideration to the needs, interest and continued satisfaction of the persons insured.

6. Endeavor to establish the insurability of persons at the time of application in every instance where such insurability is a factor in the issuance or continuance of the insurance or in the liability of the insurer.

7. Pay all just claims fairly, courteously and promptly, with a minimum of requirements.

8. Continue research and experimentation in order to meet the changing needs of the public.

9. Engage in keen, fair competition so the public may obtain the protection it needs at a reasonable price.

The Health Insurance Institute estimated that total health insurance benefits paid out this year by insurance companies, Blue Cross-Blue Shield, and other plans will total \$4.2 billion, as compared to \$3.6 billion in 1956.

New Mental Health Grant

CAMBRIDGE, MASS. — The Joint Commission on Mental Illness and Health has received a \$60,000 grant from the Rockefeller Brothers Fund to aid in a study of the rôle of religion in mental health.

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Announcing a new Du Pont Fabrilite[®] pattern featuring House and Garden colors

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Long-wearing, elastic "Fabrilite" in stay-clean pastels and deep tones for every décor . . .

Fifteen captivating colors—House and Garden pastels and other rich, deep tones—are yours to choose from in Santa Fe, the new pattern in Du Pont "Fabrilite" vinyl upholstery. "Fabrilite" is not only beautiful, but also practical, for it resists soil and wear, cleans easily

with a damp, soapy sponge. "Fabrilite" keeps your furniture looking bright and new for years . . . gives you soft seating comfort, too. Find out about the wonderful range of colors in Santa Fe . . . ask your distributor for this new pattern in Du Pont "Fabrilite."

"Fabrilite" is Du Pont's registered trademark for its elastic-supported vinyl upholstery.

SANTA FE, new elastic pattern with a Granada antique finish in Du Pont "Fabrilite." Stays beautiful through long, hard wear.

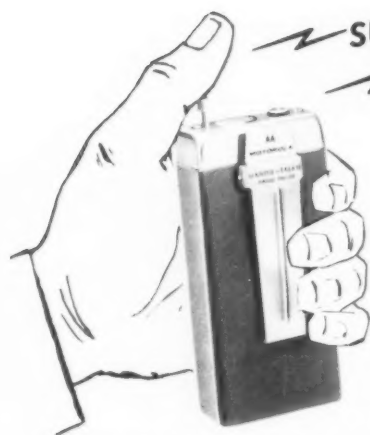


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Dr. Walter Urges Special Disinfecting Precautions During Asian Flu Crisis

ATLANTIC CITY, N.J.—The best place for persons with influenza to be is home, said Dr. Carl W. Walter at a special panel during the American Hospital Association convention here last month. The panel, convened by Lehn & Fink Products Corporation, was entitled "Asian Influenza: Its Impact on Hospitals."

Dr. Walter, clinical professor of surgery at Peter Bent Brigham Hospital, Boston, stressed the danger of secondary bacterial invaders to patients whose resistance is weakened by the flu virus. He urged hospitals to take special disinfecting precautions during the current flu crisis, citing floors, blankets, ventilation systems, and the laundry as among the worst culprits in transmitting the bacteria of secondary infection.

He referred to the "wild life" of the average hospital, which runs everywhere and may carry disease organisms.

Flu-Like Illness Kills 9 at Dixon State School

DIXON, ILL.—An outbreak of a flu-like disease has resulted in at least nine deaths and has made more than 2000 persons ill at Dixon State School, it was reported last month.

According to Superintendent Robert E. Wallace, the flu type of illness has not yet been precisely identified. Those who died were aged or in a weakened condition previously, he said. The 2000 persons on the sick list compares with a normal number of 75 to 250.

Officials at the school expected the number of cases to increase still more, it was reported.

The hospital is overcrowded, and many of the sick are being treated in their dormitories, it was reported.

There are 5000 children and adults living at the institution, which gives training to the mentally retarded.

Chronic Care Wing Opened

WATERVILLE, MAINE.—Thayer Hospital recently dedicated a 34 bed, two-story addition here to be used exclusively for diagnostic and rehabilitation services for the chronically ill. The \$550,000 wing was partially financed by a government grant. Thayer Hospital was the first small hospital in Maine, and one of the first in the nation, to receive such a grant.

When surgery, fever and other debilitating conditions increase the patient's requirements for B complex plus C, Berocca-C provides a balanced comprehensive formula in a stable injectable form **READY FOR IMMEDIATE USE.**

Berocca-C is time saving, for **IT MAY BE ADDED TO INFUSION FLUIDS**, or given by intramuscular or slow intravenous injection; it comes in labor-saving "color-break" ampuls; and **IT IS ECONOMICAL.**

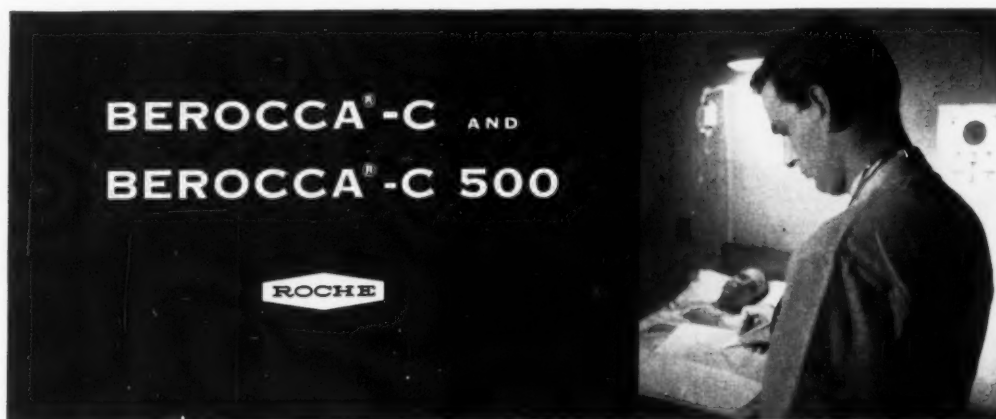
Supplied: Berocca-C, 2-cc ampuls, 20-cc vials.

Berocca-C 500, duplex ampul packages, boxes of 50.

Each 2-cc ampul of Berocca-C contains thiamine HCl 10 mg, riboflavin 10 mg, niacinamide 80 mg, pyridoxine HCl 20 mg, d-pantenol 20 mg, d-biotin 0.2 mg and ascorbic acid 100 mg. When higher amounts of vitamin C are desired, use the Berocca-C 500 duplex package containing a 2-cc ampul of Berocca-C plus an additional 2-cc ampul of vitamin C injectable 400 mg.

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Hospital Industries Group Elects Harris L. Willits, Presents Annual Awards

ATLANTIC CITY, N.J. — Harris L. Willits, president of C. R. Bard, Inc., was elected president of the Hospital Industries' Association at its annual meeting here last month, succeeding James G. Dyett.

Roland F. Simons, Ethicon, Inc., was elected vice president and president-elect, and Robert H. Brown, surgical-hospital division, Becton, Dickinson & Company, was elected vice president and treasurer of the HIA which has

been functioning for over 35 years.

Reelected to the board of directors were Reginald G. Bares, J. Sklar, C. Kenneth Cory, Clay-Adams Co., and L. J. Paxton, Simmons Co. New member of the board of directors is Louis H. Nichols, Bauer and Black.

William E. Smith, executive director of Hospital Industries' Association, presented plaques to representatives of the groups winning awards for excellence of exhibits.

The E. F. Hauserman Company was judged best in the 200 square feet or over category and the International

Nickel Co., Inc. exhibit as best in the less than 200 square feet group.

A special award was presented to the jointly sponsored Infant Formula Center in which the following organizations participated: A. S. Aloe Company; Atlantic Alloy Industries, Inc.; Davol Rubber Company; Franklin C. Hollister Company; Hospital Pictures Service Corporation; Klenzade Products, Inc.; Mead Johnson and Com-



Officers of the Hospital Industries Association, l. to r.: vice president and treasurer, Robert H. Brown; executive director, William E. Smith; president, Harris L. Willits; vice president and president-elect, R. F. Simons.

pany; Pet Milk Company; Ross Laboratories; and Southern Cross Manufacturing Company.

Certificates of honorable mention were also presented by Mr. Smith to four other companies: Magic Door Sales, Division of Stanley Works, and the National Cylinder Gas Company in the 200 square feet and over category; and Ethicon, Inc. and McKesson and Robbins, Inc. in the less than 200 square feet category.

NU Alumni to Establish MacEachern Memorial

ATLANTIC CITY, N.J. — Paul H. Keiser, administrator of Burlington Hospital, Burlington, Iowa, was named president-elect of the Alumni Association of the Program in Hospital Administration, Northwestern University, at the group's meeting held last month during the A.H.A. convention.

Carl Nusbaum, executive director of Rest Haven Rehabilitation Hospital, Chicago, was named secretary-treasurer.

The association voted unanimously to establish the Dr. Malcolm T. MacEachern Memorial Room and appropriated \$7000 for this purpose, of which \$2000 is to be paid now and the rest in the next three years.

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Roentgen Ray Society Hears Discussion on Hazards of Radiation

(Continued From Page 118)

it may be inferred that radiologists using present-day safeguards do not need to fear any significant future reduction in their life span due to irradiation," Dr. Carl D. Braestrup, radiation physicist of the Francis Delafield Hospital, New York, told the panel.

Recent reports concerning the dangers of radiation must be evaluated in terms of the remarkable advances in

medical science, in which radiology has played a major part, said Dr. Robert Stone, professor of radiology at the University of California School of Medicine, San Francisco. He also said that, in stating the amount of exposure in roentgens, too often no statement is made as to the size of the area which has been exposed.

A description of an intensifying screen, through which x-ray beams are passed to reach the film, was given by Dr. Michel Ter-Pogossian, radiation physicist at the Mallinckrodt Institute of Technology, St. Louis. The screen

makes possible a shorter length of exposure time.

Panel moderator was Dr. Edith H. Quimby, radiation physicist for Columbia University's College of Physicians and Surgeons. She noted that the really tremendous difference between the body damage to the exposed individual and the possible genetic damage to the race has not been made clear, so that people beyond the childbearing age object to dental x-rays or to examinations of broken bones. The radiologist, who is well aware that he is working with a dangerous tool, is likely to be impatient with this attitude, she added.

In summing up the panel discussion, Dr. Richard H. Chamberlain, professor of radiology at University of Pennsylvania Graduate School of Medicine, noted some of the recommendations that had not been made by the panelists.

They did not ask that any specific procedure be prohibited, state that there are too many radiological examinations or that the total number should be reduced, advise that radiologists and their co-workers should have excessive concern for their longevity, or request that every individual carry a diary of all man-made radiation exposure.

ATTEND REFRESHER COURSES

In addition to a complete look at information about hazards and protection, doctors attending the four-day meeting listened to more than 40 scientific papers on the diagnostic and therapeutic uses of radiation in medicine, attended nearly 30 postgraduate instructional courses to "refresh" them in their practical, day-to-day medical procedures in this specialty, and looked at more than 50 commercial and 35 scientific exhibits.

Dr. Eugene P. Pendergrass delivered the Caldwell Lecture at the society's 1957 meeting. His subject was "Atmospheric Pollutants and the Radiologist."

Dr. Pendergrass is professor of radiology, University of Pennsylvania Graduate School of Medicine.

Dr. Barton R. Young of Germantown, Pa., was named president-elect of the society. Other officers are: secretary, Dr. C. Allen Good, Rochester, Minn; treasurer (reelected), Dr. Robert K. Arbuckle, Oakland, Calif.; and chairman of the executive council, Dr. Wilbur Bailey, Los Angeles. Dr. Wendell G. Scott of St. Louis assumed the office of president.

DURABILITY

Edward Weck & Company April 23, 1957

Gentlemen:

In purchasing surgical instruments we obviously try to get the utmost in VALUE. And, among other things, VALUE is measured in terms of DURABILITY—how long the instruments last!

In this connection you may be interested in the following information:

Of the \$18,000 worth of Weck Instruments we purchased a year ago, only two have needed repair. So far as we are concerned this is an all-time record—positive proof that "Weck" is another way of saying "Quality".

Sincerely yours,
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Administrator

*name on request

"Of the \$18,000 worth of Weck Instruments we purchased a year ago, only two have needed repair"

"Quality", "Strength", "Durability" are merely words in the dictionary until and unless their meaning is interpreted in terms of service — day in and day out service in use — and abuse!

"Durability" is only one reason why Weck Surgical Instruments have earned the preference of both surgeons and administrators everywhere.



67 years of knowing how

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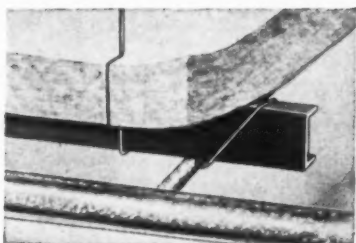
Manufacturers of Surgical Instruments • Hospital Supplies • Instrument Repairing

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**Your Building is Better
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Write for Catalog No. 138-2M

The only completely integrated Radiant Acoustical Ceiling

Completely modern, but years beyond the experimental stage, the Burgess-Manning Radiant Acoustical Ceiling has been proved in many installations in hospitals, schools and commercial buildings.

It is the perfect ceiling for the hospital, where human comfort is the primary consideration.

The Burgess-Manning Ceiling does not depend on air movement for heat transfer, hence there are no drafts. The floors are always warmer than the room temperature. The response to temperature controls is practically instantaneous, with no lag or overrun. Temperatures are practically uniform from floor to ceiling. Patients feel comfortably warm, even at lower than average room temperatures.

From the standpoint of economy, Burgess-Manning Radiant Acoustical Ceiling is equally efficient. With direct contact between coils and radiant panels, maximum heat transfer efficiency is attained with substantial fuel economy. Maintenance costs are lower. The absence of radiators, ducts, etc., means more usable floor space and lower initial accommodation costs.

From the standpoint of comfort and efficiency, there is no comparison with the Burgess-Manning Radiant Acoustical Ceiling.



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PUT NEW LIFE *into* YOUR CUSTODIAN



"FLOOR-PRINCE"
Mopping outfit for
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Geerpres wringers "baby" mops while they wring them dry. Powerful interlocking gearing smoothly squeezes water out without splashing. Mops never need to be twisted and enclosed moving parts never tear mop strings loose.

Electroplated wringers and galvanized or stainless steel buckets end rust—last for years. No wasted effort pushing Geerpres buckets around—they roll at a touch on quiet, rubber-wheeled ball-bearing casters.

Take it easy on your mops and yourself. Get Geerpres mopping equipment. Single and twin-tank models plus complete accessories. Ask your jobber for details.

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Hospitals recognize **TURN-TOWL** economy

WITHIN past months, prominent hospitals in Altoona, Pa., Columbus, Ohio, Manchester, N.H., Houston, Texas, Wilkes-Barre, Pa. and Rochester, N.Y. have switched to Mosinee Turn-Towls. They recognize that pure soft-wood fibre Turn-Towls and controlled Turn-Towl dispensing cabinets cut towel consumption so that wash-room towel costs drop sharply.

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Protest Rate Hikes by Philadelphia Blue Cross

(Continued From Page 118)

"The purpose of the city's participation in these hearings will be to develop all the facts so we can fight for a set of rates which will allow the hospitals to be fairly paid for their services but which at the same time will protect subscribers and charge all classes of subscribers fairly."

Dr. Samuel B. Hadden, president of the Philadelphia County Medical Society, criticized Blue Cross and the proposed rate increases severely in several public statements, adding the opinion that the rate increases were a "red herring" and Blue Cross would settle for smaller increases.

Hospital Representatives Named to Liability Group

CHICAGO.—Ray E. Brown, Dr. August H. Groeschel, and James E. Ludlam have been named as hospital representatives to a joint American Medical Association-American Hospital Association committee to formulate a joint medical professional liability prevention program.

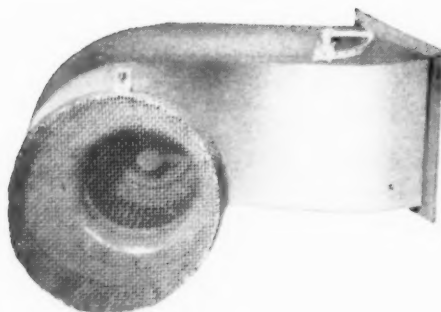
Mr. Brown is a past president of the A.H.A. and superintendent of the University of Chicago Clinics, Chicago; Dr. Groeschel is associate director, Society of New York Hospital, New York, and Mr. Ludlam is the legal counsel for the California Hospital Association, Los Angeles.

Representing the A.M.A. are Dr. Joseph F. Sadusk, Oakland, Calif., chairman of the committee; Dr. H. Close Hesseltrine, Chicago, and Dr. William M. Nebeker, Salt Lake City, Utah. The group held its first meeting here October 19.

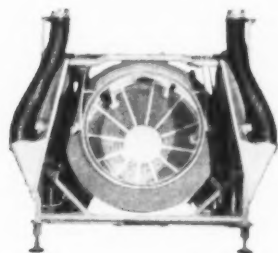
Unite Four Hospitals

NEWARK, N.J.—Four Newark hospitals have been consolidated into a single corporation, effective Jan. 1, 1958. The new institution, known as United Hospitals of Newark, will comprise Presbyterian Hospital, Hospital for Crippled Children, Babies' Hospital, and Newark Eye and Ear Infirmary.

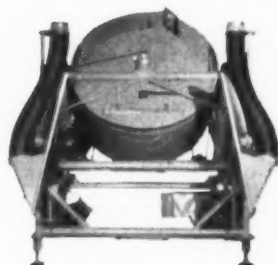
"Initially, the units will operate in the present hospital plants; but it is hoped that they may be brought together in one location when and as funds become available for erecting and equipping more modern hospital buildings," hospital officials stated.



This new 6-inch Fan gives Purkett Conditioning Tumblers about 20% more air... speeds up production



Purkett's 72" PCT* in loading position with vented doors swung clear. Handles 250 lb. load easily. Works automatically so that there is no interference with continuous operation.



It has now reversed itself to unloading position . . . notice break in blower duct. Automatic timer tells when it's time to unload and push button control does it automatically.

Provides more drying in the same length of time with shorter tumbling time possible.

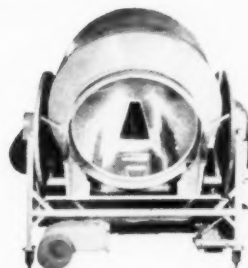
A 72-inch 12-ring Purkett Pre-Drying Conditioning Tumbler with the new 6-inch fan, delivering 2,000 cfm, the larger 1½ hp. motor and larger duct, will definitely improve your flatwork and garment conditioning operations.

It will be possible for you to obtain the same amount of drying with a shorter tumbling cycle or more drying in the same amount of tumbling time you are now using.

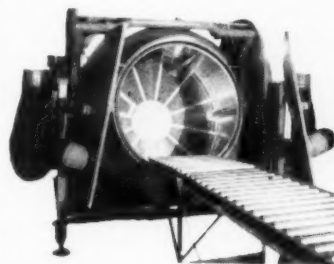
This is just one more example of how Purkett keeps far ahead in the development of superior conditioning equipment. The many features of their tumbler are described in a folder which will be sent gladly upon request.

Free Consulting Service

Ask for a Purkett engineer to consult with you on your special problems. He is a specialist in linen and garment conditioning . . . of course there is no cost or obligation to you.



Unloading position from ironer side showing powerful 6" blower, also removable cleaning "door" to get to coils. Tumbling action speeds up ironing by eliminating costly manual shakeout; the goods are in a pre-determined condition for better ironing.



If you use the hydraulic or squeeze type extractor the 72" "Bigmouth" will handle your needs readily.

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COMING EVENTS

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Regional Membership Conference: Region 9, Chicago, Nov. 11-15.

CONNECTICUT HOSPITAL ASSOCIATION, Conn. Light & Power Co., Berlin, Conn., Nov. 13.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Dec. 5, 6.

KANSAS HOSPITAL ASSOCIATION, Broadview Hotel, Wichita, Nov. 14, 15.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Nov. 6-8.

OREGON ASSOCIATION OF HOSPITALS, Eugene Hotel, Eugene, Nov. 4, 5.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Chamberlin, Old Point Comfort, Nov. 15, 16.

1958

ALABAMA HOSPITAL ASSOCIATION, Hotel Stafford, Tuscaloosa, Jan. 30, 31.

AMERICAN COLLEGE OF SURGEONS, Joint Nurses-Surgeons Meeting, Commodore Hotel, New York, March 3-6.

ASSOCIATION OF OPERATING ROOM NURSES, Bellevue-Stratford Hotel, Philadelphia, Feb. 10-12.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, April 21-24.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 24, 25.

CATHOLIC HOSPITAL ASSOCIATION, Atlantic City, N.J., June 21-26.

COMITE DES HOPITAUX DU QUEBEC, Montreal Show Mart, Montreal, Que., June 25-27.

GEORGIA HOSPITAL ASSOCIATION, Raiston Hotel, Columbus, Feb. 20-21.

KENTUCKY HOSPITAL ASSOCIATION, Sheraton-Seelbach Hotel, Louisville, April 15-17.

LOUISIANA HOSPITAL ASSOCIATION, Bellemont Motor Hotel, Baton Rouge, March 20-22.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Nov. 3-5.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 21-23.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., March 24-26.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 24-26.

OHIO HOSPITAL ASSOCIATION, Netherland-Hilton Hotel, Cincinnati, March 10-13.

SOUTHEASTERN HOSPITAL CONFERENCE, Hotel Fontainebleau, Miami Beach, Fla., May 14-16.

TEXAS HOSPITAL ASSOCIATION, Statler-Hilton Hotel, Dallas, May 5-8.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 28-30.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis Auditorium and Leamington Hotel, Minneapolis, May 14-16.

WEST VIRGINIA HOSPITAL ASSOCIATION, Daniel Boone Hotel, Charleston, Oct. 15-18.



Vaccine is the FIRST
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NOW environmental disinfection
is imperative.

When the Asian Flu Virus hits the hospital, its spread will be rapid and relentless. Disinfection of patient rooms and public areas is positive action the hospital should take to control spread of Asian Influenza.

Amphyl®, O-syl®, and Lysol® kill the Asian Flu Virus. These wide spectrum Lehn & Fink disinfectants also kill infectious organisms which cause feared secondary complications of Asian Influenza.

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Polio Foundation Would Support Construction of Nursing Homes: O'Connor

ATLANTIC CITY, N.J.—"The National Foundation for Infantile Paralysis would be disposed to do all it could to support the construction of nursing home facilities by general hospitals," according to a statement by Basil O'Connor, president of the foundation. Mr. O'Connor's statement was made at a press conference held during the American Hospital Association convention here last month. He tempered his remark by noting that the foundation has a policy against buying "bricks." "We would not indulge in a project of building," he stated.

"The foundation feels it has a moral obligation to the post-acute polio patient," Mr. O'Connor said, adding, "We have many custodial patients on our rolls."

"We would consider the care of some of these persons in hospital operated nursing homes. We now operate a number of regional respirator centers which are becoming rehabilitation centers. We would be disposed to do everything we could," he said.

Asked what advice he would have for an administrator contemplating such a building program, Mr. O'Connor said: "First he should determine if the situation warrants such a building. It should be financed on the local level. Such a program, if adequately portrayed, will bring public response."

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ABOUT PEOPLE

(Continued From Page 75)

Bernard Entman has assumed the position of assistant executive director of Orthodox Jewish Home for the Aged, Chicago. He succeeds **Melvin Dray**, who has been appointed administrator of Jewish Home of the Northwest, St. Paul, Minn.

R. L. Olsen has been appointed administrator of Itasca Memorial Hospital, Grand Rapids, Minn. He formerly was assistant administrator at Presbyterian Hospital Center, Albuquerque, N.M.

Robert C. Krutz has been named assistant administrator of Citizens General Hospital, New Kensington, Pa. He is a graduate in pharmacy of the University of Pittsburgh and received a master's degree in public health from that institution in June. He recently



Robert C. Krutz



Frank P. Mazza

completed a two-year residency at Citizens General. At the same time it was announced that **Frank P. Mazza** has been appointed administrative assistant. Previously he served as purchasing agent for four years and as office manager for one year.

Paul M. Schmoll, assistant manager of the Veterans Administration Center, Fargo, N.D., has been appointed manager of the V.A. Center in Whipple, Ariz. He succeeds **Dr. Thomas O. Lake**, who has retired.

T. P. Hipkens, former rehabilitation administrator with the Pittsburgh office of the United Mine Workers Welfare and Retirement Fund, has been named executive director of the Industrial Home for Crippled Children, Pittsburgh.

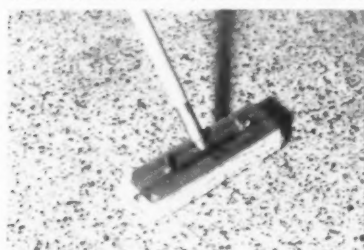


T. P. Hipkens

Beatrice K. Palen has been appointed assistant hospital administrator in



With efficient, fast-working cleaners and equipment, your men strip wax or scrub and pick up in fraction of time needed by old fashioned methods.



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You'll be under no obligation.



charge of nursing service at Crouse-
Irving Hospital, Syracuse, N.Y. Miss
Palen received her nursing degree from
St. Mary's Hospital School of Nursing,
Rochester, Minn., and her bachelor's
and master's degrees from Syracuse
University.

Dr. Robert Guy Blackwelder has
been named superintendent of West-
ern State Hospital, Hopkinsville, Ky.
Previously he was superintendent of
Andrew S. Rowan Memorial Home, a
state home for the aged in Sweet
Springs, W. Va. **Dr. Milton M. Green**,
who has been acting superintendent of

the Hopkinsville hospital, will remain
as a staff physician.

William Kersh has been appointed
superintendent of Memorial Hospital,
now under construction at Cordell,
Okla. The hospital is scheduled to
open next summer. Mr. Kersh also
will continue his position as manager
of Southwest Baptist Hospital, Man-
gum, Okla.

Howard B. Lehwald has assumed the
position of administrator at St. Luke's
Hospital, Marquette, Mich. He for-
merly was administrator of Chippewa
County War Memorial Hospital, Sault

Ste. Marie, Mich. Mr. Lehwald suc-
ceeds **Audrey Shade, R.N.**, who re-
signed after 10 years of service to
take an extended vacation.

A. W. Chipman, formerly assistant
administrator at James Decker Mun-
son Hospital, Traverse City, Mich., for
eight years, has been named assistant
administrator of Alpena General Hos-
pital, Alpena, Mich.

Dr. Benedict Nagler, chief of the
Veterans Administration's neurology
division, Washington, D.C., has left
the V.A. to become superintendent of
Lynchburg Training School and Hos-
pital, Colony, Va. Dr. Nagler joined
the V.A. in 1946 and was appointed
chief of the neurology division in 1953.
He is on the teaching staffs of George-
town University and the Medical Col-
lege of Virginia.

Charles Becker, formerly adminis-
trator of Davidson County Tuberculosis
Hospital, Nashville, Tenn., has been
named administrator of **Burnham City
Hospital**, Champaign, Ill. He succeeds
William B. Robinson, whose appoint-
ment as administrator of Ryburn Me-
morial Hospital, Ottawa, Ill., was re-
ported in the September issue of *The
MODERN HOSPITAL*.

Department Heads

Frances I. Purdy, R.N., has been ap-
pointed director of nursing at Beckman-
Downtown Hospital, New York. Miss
Purdy, a graduate of the Temple Uni-
versity nursing education program, has
served in various teaching and admin-
istrative capacities at several Pennsylv-
ania hospitals. She has held a number
of offices in the American Nurses' As-
sociation and the National League for
Nursing.

Gen. Clarence P. Canby has been
appointed director of dental activities
at Walter Reed Army Medical Center,
Washington, D.C. Formerly he was
chief of the dental service at Letter-
man Army Hospital, San Francisco.

Archibald C.

Eglin Jr., associate
controller of Jeffer-
son Medical Col-
lege and Hospital,
has been ap-
pointed controller.
He succeeds
George M. Ritchie,
who died in September. Prior to Mr.
Eglin's association with Jefferson, he
was assistant director of the Hospital
Council of Philadelphia.

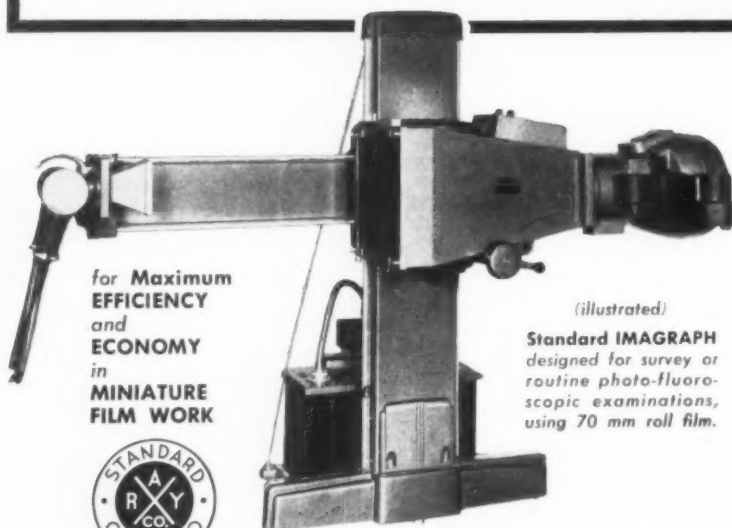
(Continued on Page 142)



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and
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FILM WORK



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Standard IMAGRAPH
designed for survey or
routine photo-fluoro-
scopic examinations,
using 70 mm roll film.

SUPERIOR OPTICS utilizing the Bouwers Concentric Mirror System

The superb new Odelca Camera enhances the efficient, economical operation which has always marked the Standard IMAGRAPH. Employing ingenious optics based on the use of the Bouwers concentric mirror system, the IMAGRAPH with the Odelca requires ONE-FOURTH the patient exposure to x-ray of refractive-lens cameras, yet produces photographic images so rich in detail as to permit accurate diagnosis, without magnification.

Models available for work in both horizontal and vertical planes, using 70 mm or 100 mm (4" x 4") roll film. Inquiries are invited . . . literature sent on request.

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ies from coast-to-coast, are
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stall and maintain Stand-
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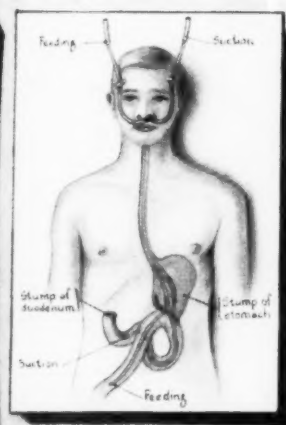
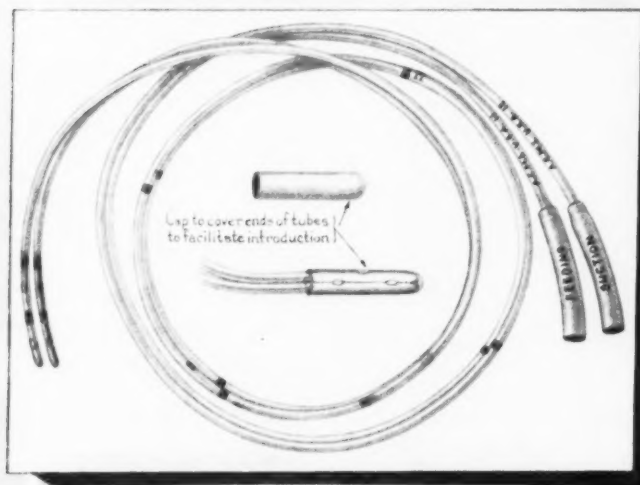
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by A.C.M.I.
FOR USE IN GASTRIC SURGERY

The Trimble Suction and Feeding Tubes consist of two non-irritating, light weight polyvinyl catheters of 12 Fr. calibre with multiple openings in the distal ends. A removable cap covers the tips of the tubes to facilitate introduction.

In gastrojejunostomy, the suction tube is used to drain the duodenal and biliary secretions and to take pressure off the closed duodenal stump. Additional holes in the tube serve to drain the gastric stump. The feeding tube is placed into the distal end of the jejunum and provides water, saline solution, glucose solution and a liquid diet.

In the Billroth I operation, the suction tube is left in the stomach and the feeding tube is advanced into the duodenum.



FEATURES

- Drainage of stomach, and proximal and distal loop of jejunum
- Feeding of patient through jejunum
- Refeeding, when thought desirable, of contents of gastric suction down feeding tube
- Stabilization of all three limbs of gastrojejunostomy, reducing possibility of post-operative stomal obstruction
- An aid to early intestinal peristalsis
- Avoidance of intravenous therapy
- Non-irritating quality, small size and light weight of tubes
- Simplicity of apparatus

*Trimble, I. R. and Nouri, J.: A New Technique Combining Suction and Feeding for use in Gastric Surgery. J.A.M.A. Aug. 13, 1955.

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for information

(Continued From Page 140)

John R. Busick has been appointed director of development for Alexandria Hospital, Alexandria, Va., to take charge of completing the fund raising campaign for construction of the new hospital. Mr. Busick has been director of medical information for the University of Pennsylvania and has directed public relations for George Washington University, for Miami Valley Hospital, Dayton, Ohio, and for Group Hospitalization, Inc., the Blue Cross plan for the Washington, D.C., area.

Donald Larson has been appointed

personnel relations manager for Passavant Memorial Hospital, Chicago. He previously was personnel director for a manufacturing company for seven years. At the same time it was announced that **Audrey Hesser** has been appointed assistant personnel relations manager, succeeding **Elaine Purke**, who will become personnel director at Ball Memorial Hospital, Muncie, Ind.

James A. Betts Jr. has been appointed to the newly created post of director of public relations and development at Muhlenberg Hospital, Plainfield, N.J. Formerly he was executive director of

a New York Y.M.C.A. He is a graduate of Lafayette College and received his bachelor of laws degree from the University of Richmond Law School.

Dr. Richard H. Kosterlitz has been appointed director of medical education for Washington Medical Center, an 800 bed hospital soon to be completed in Washington, D.C. Dr. Kosterlitz, a specialist in internal medicine, will devote his time to teaching, developing and coordinating training programs for interns and residents, as well as a scientific program for attending staff. He has served on the staffs of Cook County Hospital and Mount Sinai Hospital in Chicago, and received his medical degree from the University of Illinois College of Medicine.



Dr. Richard H. Kosterlitz

Miscellaneous

Louis S. Reed, formerly health economist, occupational health program, U.S. Public Health Service, and associated with the federal government for 22 years, has accepted a position as associate professor of medical economics at the Sloan Institute of Hospital Administration, Cornell University.



Louis S. Reed

Grant Adams has been appointed executive director of the United Hospital Fund of New York. Mr. Adams, a graduate of the University of Chicago, has been assistant director for the last three years. He formerly was active in hospital work in Chicago. Mr. Adams succeeds **R. O. D. Hopkins**, who has retired from active direction of the fund after more than 20 years as executive director and executive vice president. Mr. Hopkins will continue to serve as a consultant.



Grant Adams

Daniel S. Schechter, chief of public relations activities for the American Hospital Association, has been named secretary of the Council on Research and Education. He will continue to hold the public relations appointment. **Hiram Sibley** has been appointed secre-



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Now tiniest dietary aides take heaviest-loaded food conveyors anywhere! New safety!

Touch the button as you walk ahead. The Blickman "Touch-n-Go" Foodveyor follows behind you, *under its own power*. In and out of elevators, around corners, up and down hospital ramps, now female dietary aides can take heaviest-loaded food conveyors anywhere!

Simple and instantaneous Blickman "Touch-n-Go" power drive has thumb-button controls recessed in steering handle.

Safer than any other conveyor made! Look at these safety advantages you get only with Blickman "Touch-n-Go" Foodveyor!

- Operator walks *ahead* of Foodveyor! For the first time, operator has unimpeded vision and cannot "run down" obstacles—because she doesn't push, she leads, and conveyor follows behind.
- Controlled speed—foodveyor cannot run away, even holds back on ramps. Slow forward speed for safety. Quarter-speed reverse!
- *Instant response* when thumb presses button.
- *Instant power brake* acts the moment thumb is taken off button. "Touch-n-Go" Foodveyor stops in inches even on ramps!

Full clearance under conveyor—vital for elevators, ramps, doorsills.

Less labor, less muscle. Each Foodveyor takes heavier load, speeds service, reduces number of trips. Eliminating duplication of personnel, the "Touch-n-Go" reduces hospital dependence on custodial labor.



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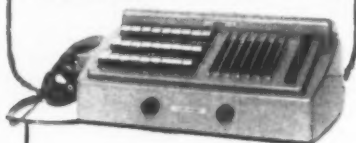
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DOES YOUR HOSPITAL GET THESE BENEFITS?

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Instant 2 way visual and audible contact with all stations including priority emergency signal circuit.

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Single or dual stations provide nurses' call service with or without 2 way communication between patient and nurse.

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2 way communication between nurse and ambulatory patient and ability to reach nurse in any location where she normally may be found.

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Only DuKane gives the hospital a **MULTIPLE Channel Nurses' Call System** to multiply Bedside Communications Channels. It permits the use of 2 or more Nurses' Master Stations in which separate calls may be answered from any Master Station simultaneously. Countless steps are saved as a nurse need not return to the central desk to answer calls. Speeds service, increases efficiency . . . saves costs!

Write for the beneficial facts today!

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tary of the Council on Planning, Financing and Prepayment, which was formed through the combination of the Council on Hospital Planning and Plant Operation and the Council on Prepayment Plans and Hospital Reimbursement. Mr. Sibley had been secretary of both councils.

Jean H. Campbell, R.N., has been appointed assistant director of the National League for Nursing, as part of the league's extension of services to



Jean H. Campbell, R.N.

strengthen college programs in nursing. The program, financed by a three-year grant from the W. K. Kellogg Foundation, is a part of the department of baccalaureate and higher degree programs. Miss Campbell formerly was professor of education at New York University and lecturer in the nursing science program at Queens College, Brooklyn. A graduate of Kings County Hospital School of Nursing, Brooklyn, she received bachelor's and master's degrees in nursing education from New York University and a doctorate from Columbia University.

Dr. John D. Porterfield has been appointed deputy surgeon general of the U.S. Public Health Service. He has been assistant surgeon general since March 1957.

Robert G. Crist

has been appointed to the new post of assistant director of the Hospital Association of Pennsylvania. The appointment continues an affiliation with the association begun in 1950 when Mr. Crist and his father became editors of the monthly newspaper and public relations consultants. Mr. Crist and his wife also are editors of the Middle Atlantic Hospital Assembly newspaper.



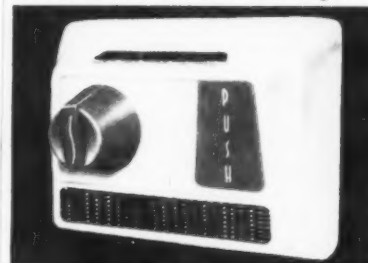
Robert G. Crist

William A. Werdel has been appointed assistant professor of hospital administration in the school of business administration at the University of Michigan. Mr. Werdel currently is a teaching assistant at the State University of Iowa. He has been a laboratory technician at Finley Hospital, Dubuque, Iowa, and at New England Center Hospital, Boston. At the same time it was

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Hoffman laundry, dry cleaning and pressing equipment has long been known for its superior design, quality construction, ease of operation, productive capacity. Backing up the complete Hoffman line, the Nicholson organization is set up to give you the dependable service you need to keep your plant operating at top efficiency.

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any height . . . any spring position
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● This new Hill-Rom Hilow Bed is designed so that operation of the hilow feature and adjustment of the backrest and knee rest may be handled by either patient or nurse. Push button controls for patient use are located on the patient's right—in the seat section of the spring. For the patient who must remain in a certain prescribed position, the bed may be placed in that position and the patient control switches then rendered inoperative. All switches are mechanically interlocked—no two push buttons can be operated at the same time.

Maximum convenience for the nurse, maximum comfort and safety for the patient

This modern, safe and efficient hilow bed can be maintained at the "low" position at all times to insure maximum safety. Much time will be saved the nurse by elimination of unnecessary trips to the patient room or unit. The patient has access to head and knee rest and does not need the nurse for routine adjustment of the spring.

Head end and foot end panels, designed by Raymond Loewy, add to the appearance and function of the bed. For complete information on this or any of the three other Hill-Rom Hilow Beds, write for Procedure Manual No. 3.



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Now ready . . . Procedure Manual No. 3—"Hilow Beds" by Alice L. Price, R.N., M.A., Nurse Consultant for Hill-Rom, and author of three leading textbooks on nursing, also P.M. No. 1, "Safety Sides—A New Safety Measure" and P.M. No. 2, "The Recovery Bed, Labor Bed, Special Therapy Bed." Copies of any of these manuals for student nurses and graduate nurse staff will be sent on request. Address: Miss Alice L. Price, Hill-Rom Co., Inc., Batesville, Indiana.

announced that Edward J. Conners has been promoted from instructor to assistant professor of hospital administration at the University of Michigan.

Dr. Carlyle Jacobsen has been appointed to the newly created position of president of the State University of New York Upstate Medical Center at Syracuse. Dr. Jacobsen is now executive dean for medical education with offices in Albany, N.Y. He will assume his new duties on December 1.

Floyd K. McTyler has been named accounting associate for the Hospital Council of Western Pennsylvania. Previously he was business director of Woman's Hospital of Philadelphia for six years. He also has held positions in public and industrial accounting.



Floyd K. McTyler

Dr. W. Edward Chamberlain, professor emeritus of radiology at Temple University Medical School and past president of the American Roentgen Ray Society, has been named to head the Veterans Administration atomic medicine program in Washington, D.C. Dr. Chamberlain was director of Temple University Hospital's department of radiology and professor of radiology at the medical school from 1930 until February 1957.

Mary G. Munger has been appointed executive secretary of the Federal Hospital Council, succeeding Charles Hilsenroth, who has been named executive officer of the Bureau of Medical Services in the U.S. Public Health Service. Mrs. Munger has been a member of the council staff since its inception.

Dr. Theodore A. Schramm has been appointed acting director of the community services division of the Kentucky Department of Mental Health. Dr. Schramm recently completed three years of residency training in psychiatry under the direction of the University of Louisville's department of psychiatry. During his training, he served one year at Central State Hospital, Lakeland, Ky., as a staff psychiatrist.

Dr. Julius Lane Wilson, director of the Henry Phipps Institute of the University of Pennsylvania, has been named chief consultant to the V.A. director of tuberculosis service, Dr. W. B. Tucker. Dr. Wilson will serve as principal ad-

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U. S. Koylon Foam gives patients better, deeper, more beneficial sleep. That's because this mattress gives perfect support, reduces disturbing pressure points, and minimizes danger of bed sores. And further, from a hospital management point of view, Koylon has no equal. As proven for over 20 years, a U. S. Koylon Foam mattress *wears, lasts, stands up*. Is highly sanitary. Always odorless. Cool in summer, comfortable the year 'round. Non-allergenic and vermin-proof. Light and easy to handle. Specify 4½" U. S. Koylon in Silver Label or our famed double-core Platinum Label. Send the coupon below for complete details.



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viser to the director of the T.B. service and as liaison between the medical profession and the V.A. department of medicine and surgery on matters pertaining to tuberculosis. Dr. Wilson has been director of medical education for the American Trudeau Society for the last five years, and a V.A. consultant for more than 10 years.

Dr. Ruth E. Church has been appointed deputy director in charge of the division of hospitals and chronic illness of the Illinois Department of Public Health. She succeeds **Dr. G. Howard Gowen**, who resigned to join

the International Cooperation Administration in Santiago, Chile. Dr. Church received a degree in nursing from Milwaukee-Downer College, a medical degree from the University of Wisconsin, and a master's degree in public health from Columbia University. She has been associated with the Illinois department since 1945.

H. R. Bryden has been appointed acting associate editor of *Hospital Progress* magazine. He succeeds **F. J. Doyle**, whose resignation was effective August 1. Mr. Bryden has been assistant editor of the publication for more

than a year and is also editor of *News Briefs*, an internal newsletter of the Catholic Hospital Association.

Jack Miller has been named purchasing agent for St. Mary's Hospital, Cincinnati. He formerly was purchasing agent for Children's Hospital, Cincinnati, for three years.

E. Todd Wheeler has joined Perkins & Will, architects-engineers, Chicago and White Plains, N.Y., to offer consulting service for the hospital, health



E. Todd Wheeler

and medical education fields. Mr. Wheeler was a partner in the firm of Perkins, Wheeler & Will, Chicago, from 1936 to 1944. In addition to consulting in the hospital field, Mr. Wheeler has been director of planning for Chicago Medical Center Commission, assistant to the state architect of Illinois, and assistant to the vice president, University of Illinois, Chicago branches. He is a fellow of the American Institute of Architects.

Rudolf J. Pendall has been appointed executive vice president of the Ryall Corporation, a hospital public relations consulting firm with headquarters



Rudolf J. Pendall

in Kansas City, Mo. Mr. Pendall is a former editor of *Hospital Progress* and served as secretary of a hospital public relations counsel for six years. He received his bachelor's degree in journalism at the University of Wisconsin and his master's degree in administrative medicine at Columbia University, where he was the first person to do graduate work in administrative medicine public relations.

Dr. John J. Blasko, former Connecticut commissioner of mental health, has been appointed chief of the Veterans Administration psychiatry division in the psychiatry and neurology service, Washington, D.C. He will succeed **Dr. Stewart T. Ginsberg**.

Deaths

The Rev. Mother Jean Marie Greeley, 70, Mother General of the Sisters of the Third Order of St. Francis, Regulars, died recently in Olean, N.Y. She was president of St. Clare's Hospital



How Supersoft Napkins can reduce bed linen costs

Eating in bed is tricky business even for a steady hand. The obvious hazard is spilling which can mean soiled bed linens and the time lost in making changes.

For a measure of protection that flimsy paper napkins could never offer, serve with quick-absorbing Supersoft multiple-ply Napkins. Of finest facial tissue, Supersoft Cellostrength Napkins are treated to retain strength even when wet.

Too, their softness, their whiteness and their quality are so distinctive as to invite comments of pleasure from your patients. Many hospitals have already discovered how inexpensive it is to provide protection and gain good public relations with Supersoft Napkins. Quantity orders can be custom embossed or printed with hospital name, address, insignia, etc. Write today for your nearest supplier's name.

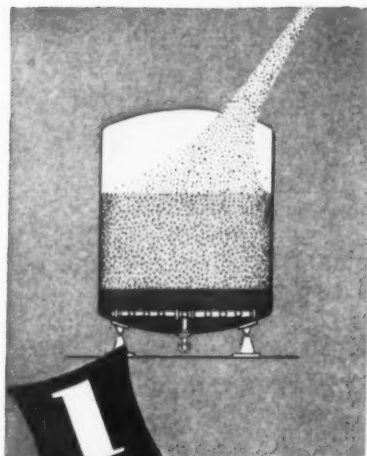


SUPERSOFT's multi-ply design provides more surfaces to absorb more moisture faster.



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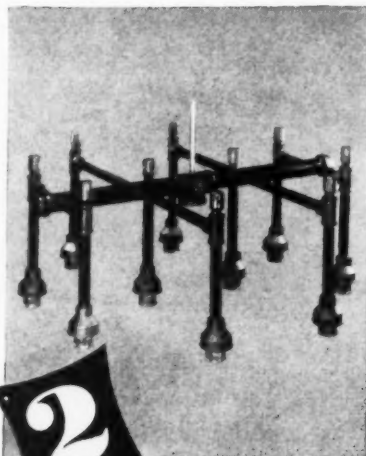
Three Ways to Get MORE SOFT WATER



By Refilling Your Water Softener With New High Capacity Elgin Zeolite you can get 3 to 10 times more soft water.

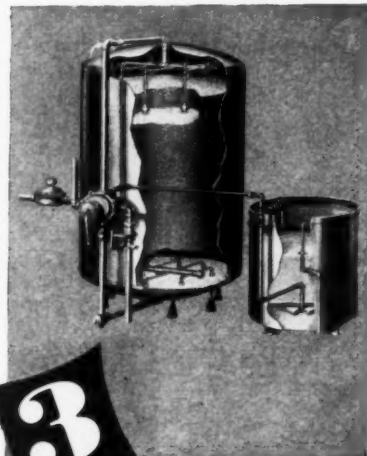
Think of it, from 3 to 10 times more soft water from your present water softener by simply refilling it with one of Elgin's new high capacity zeolites. Here is a dividend-paying investment you can't afford to pass up. In addition, regeneration will be required less frequently with savings in regeneration time and salt costs.

Replacement of lost or worn-out zeolite also will provide increased soft water output. All types of zeolite are available for immediate delivery.



By Equipping Your Water Softener With An Elgin "Double-Check" Manifold System which permits the use of a deeper zeolite bed to further increase capacity as much as 44%.

The ingenious Elgin "Double-Check" manifold system makes it possible to place far more zeolite in a water softener and to utilize it more efficiently. Capacity increases of as much as 44% can be secured. Loss of costly zeolite will be prevented too. Higher brining and backwashing efficiencies will be obtained. Here is another low cost answer to the need for more soft water.



By Installing A New Elgin Water Softener of "Double-Check" Design which gives up to 44% more soft water than softeners of conventional design.

Where new equipment is required, here is today's outstanding buy. Size for size, the Elgin Water Softener of "Double-Check" design delivers up to 44% more capacity than water softeners of conventional design. This big increase is due to the ingenious "Double-Check" manifold system of the Elgin which permits far more zeolite to be placed in the softener without zeolite loss. Get the facts about this amazing water softener before you buy.

... and some added Elgin Services for Hospitals ...

ELGIN DEALKALIZERS prevent corrosion of steam and condensate lines the basic economical way. Savings in piping, repairs and chemical treatment expense pays Dealkalizer cost many times over.

ELGIN DEIONIZERS produce mineral free water to replace distillation at a fraction of distillation cost.

ELGIN DEAERATING HEATERS supply pre-heated boiler water free of trouble-causing CO₂ and oxygen . . . pay real dividends on investment.

ELGIN SOFTENER CORPORATION • 144 North Grove Avenue, Elgin, Illinois



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|--|---|
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| <input type="checkbox"/> Modernizing present water softener | <input type="checkbox"/> Facts about Elgin Deionizers |
| <input type="checkbox"/> Complete facts covering Elgin "Double-Check" Softener | <input type="checkbox"/> Facts about Deaerating Heaters |

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Mail to Elgin Water Softener Corporation, 144 N. Grove Avenue, Elgin, Illinois

Nightingale's VARIABLE HEIGHT BEDSIDE LAMP



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Underwriters'
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This versatile lamp has same height adjustment as a Variable-Height Bed — reflector is always just the right position for patient. Convenient plug-in receptacle, 7½ watt night light and switches always at mattress level. Bulb shield provides soothing, reflected light, for reading or indirect illumination. Ventilated reflector rotates full 360 degrees, will not twist or break wires.

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and St. Elizabeth's Hospital, New York.

Mary Ann Garvey, R.N., died recently of a heart attack at the age of 55. Miss Garvey had served as director of nursing service at Athens-Limestone Hospital, Athens, Ala., since July.

Parker B. Francis, chairman of the board of the Puritan Compressed Gas Corporation, Kansas City, Mo., died recently at the age of 71. Mr. Francis was a founder of the company in 1913 and served as its president from 1932 until he was made chairman last January.

THE BOOK SHELF

CARE OF THE LONG-TERM PATIENT.

Chronic Illness in the United States, Vol. II. Commission on Chronic Illness, a Commonwealth Fund Book, Harvard University Press, 1956. Pp. 606. \$8.50.

This volume, second in the definitive series published by the Commission on Chronic Illness, deals with the case of the long suffering patient whose heritage has been neglect, indifference and rustication. It is packed with valuable information on the subject, although the conclusions, which might serve as a guide for institutional and community action, are still somewhat unclear and lacking in forthrightness.

The literature on the subject has become voluminous in the last decade, but this prolonged phase of illness has been impressing itself on the public largely through the increasing weight of sheer numbers, as well as long existing humanitarian need. Whatever the reason, this book proves that we now have the means to overcome three historic obstacles to reorganization: (a) diminishing interest on the part of the physician as chronicity takes hold; (b) medical indigence, which involves the poor patient in a vicious circle, and (c) lack of beds when the claim of the "chronic" is compared with the claim of the "acute."

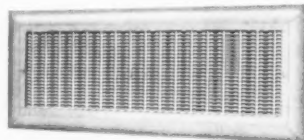
A variety of new organizational and administrative remedies are reported here, but none of the others compares with the therapeutic organization, recommended by me over three decades, by which "acute" and "chronic" are integrated in the general hospital (supported by an extramural home care program) on a continuing basis, involving the coalescence of the medical and social points of view. It is gratifying to read in these pages that such integration is the most promising means

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Model V-31:
37" x 25" x 30"
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An exacting testing and production oven that provides very close heat uniformity. Built-in indicating temperature controls. Emphasis has been on heavy construction . . . even heat distribution . . . capacity loads at high speed . . . ability to "stand the gaff"—even under continuous 24-hour-a-day usage. Six sizes and types are available for the endless variety of heating, drying, baking and testing processes. Write for Bulletin No. 107.

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of doing justice to the patient suffering from prolonged illness and that this plan of organization also satisfies the requirements of physician as well as social worker.

The bibliography might have been improved upon with a freer hand given to the scholar, for the benefit of the student who wants to read abbreviated passages *in extenso*. It seems a pity, but not a single contribution of mine on the subject of prolonged illness (I do not refer here to home care) is identified anywhere in this volume, though its significance is visible on every page.—E. M. BLUESTONE, M.D.

FIRE SAFE HOSPITALS. By the National Board of Fire Underwriters, August 1956.

This newest edition of the fire safety book for hospitals by the National Board of Fire Underwriters is well done and should be read by everyone connected with hospital administrative and engineering staffs.

The following quotation from the first paragraph of the book is worthy of note: "Fire safety in hospitals is dependent upon a properly balanced combination of good building construction proper attention to safeguards for special hazards, adequate fire extinguishing facilities, and a well organized fire and evacuation procedure. There must also be continuing and administrative attention to all of these features, the responsibility for which rests in the main with the administrator. To assist in carrying out this responsibility, it is recommended that monthly fire safety inspections be made using an inspection blank, such as the one reprinted at the end of this booklet."

The section on new hospital construction covers many interesting points on construction types to be used. In this connection the chapter dealing with fire separation between stories is of particular importance. Other topics covered in some detail in this section include subdivision of long corridors, exits and combustible interior wall and ceiling finishes. The short paragraph on combustion interior wall and ceiling finishes advises that only materials having a flame spread rating of 75 or less be used and says that the type of material to meet this standard are listed in the Underwriters' Laboratories, Inc., fire protection equipment list.

(Continued on Page 154)

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A wide choice of colors, in J-M Terraflex tile, makes possible a number of decorative patterns and colorful flooring designs.

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MADE OF VINYL PLASTIC, reinforced and strengthened with indestructible asbestos fibres, Terraflex tile will outwear most other types of decorative floor coverings two to one.

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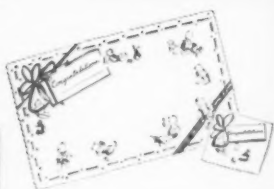
only attention this remarkable flooring requires throughout its long, trouble-free life.

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For more specific information on Terraflex Vinyl Asbestos Tile, write to: Johns-Manville, Box 158, New York 16, New York.



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Why not let us send you samples at once!

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(Continued From Page 152)

This list can be obtained from the Underwriters' Laboratories, 207 E. Ohio Street, Chicago 11, Ill. For people on the East Coast, the inquiry can be addressed to 161 Sixth Ave., New York 13, and in the West material can be obtained from the Underwriters' Laboratories headquarters at 1655 Scott Lane, Santa Clara, Calif.

The section devoted to improving existing buildings covers hazardous conditions which make continued use of buildings unsafe and devotes considerable attention to the subject of closing in floor openings as a means of preventing rapid spread of fire. The bulletin points out that laundry and trash chutes should be provided with self-closing fire doors at each opening, and that an automatic sprinkler head should be located at both the top of the chutes and in the terminal rooms at the bottom openings.

The booklet places considerable emphasis on the necessity for subdividing large areas in older buildings. The great importance of automatic sprinkler systems is pointed out.

Special fire hazards and their safeguards in connection with heating equipment, gas piping and appliances, air conditioning and ventilating systems, electric wiring and appliances, operating rooms, combustible anesthetic cylinder storage, nonflammable medical systems, x-ray departments, laboratories, pharmacies, flammable liquid storage rooms, internal combustion engines, refrigerating systems, kitchens, incinerators, laundries, sewing rooms, maintenance shops, and storage spaces are adequately covered.

Of course, the importance of good housekeeping is stressed.

Another excellent section covers automatic sprinkler systems, automatic fire protection systems, standpipe and hose systems, and hand fire extinguishers. A clear explanation is given of the type of fire extinguisher to be used for Class A, B and C fires.

The manual urges hospital administrators to make use of facilities of local fire departments and stresses the importance of regularly conducted fire drills. An excellent outline of rules for safety in case of fires is included.

A list of reference reading material from the National Board of Fire Underwriters, the Underwriters' Laboratories, Inc., the National Fire Protective Association, and the American Society of Refrigerating Engineers is included in the booklet.—E. W. JONES.

HOSPITAL PLAQUES

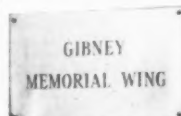
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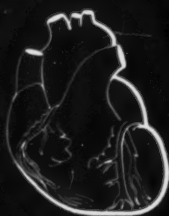
Using Camera A or B

Cerebral angiography



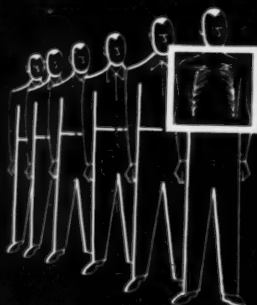
Using Camera A or C

Angiocardiography,
angiography



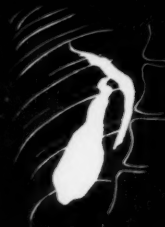
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Fairchild-Odelca cameras are now available in these three standard models—

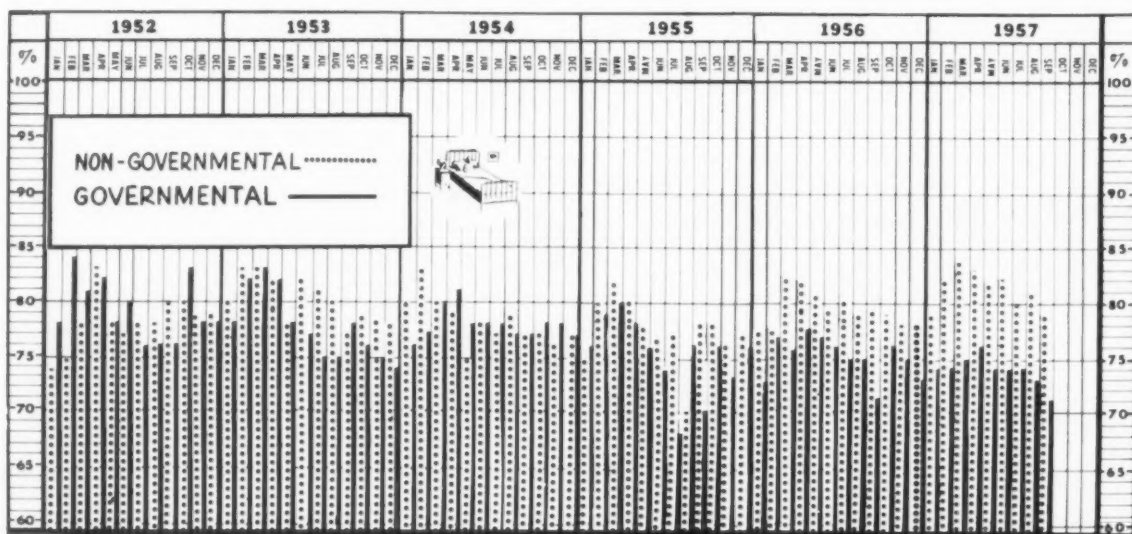
- A. The 4" x 4" Ultra Speed Camera
- B. The 70 mm. Super Speed Camera
- C. The 70 mm. Skull Camera

All of these cameras provide exceptional economy through low film cost and minimum storage space. All are easy to operate, and can be equipped with cassettes capable of taking single exposures, or up to 40 exposures in a single series, at a rate up to six (6) exposures per second.

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Voluntary Hospitals Report Increase in Occupancy



According to their reports to the Occupancy Chart for the month of September, voluntary hospitals were filled to 79 per cent of capacity; government hospital occupancy was 71.3 per cent. A year ago, percentages of

78.5 and 71.8, respectively, were reported.

From September 16 through October 14, construction amounted to \$124,002,450, bringing the total for the year thus far to \$1,033,830,952.

For the comparable period last year, building totaled \$64,168,890 and brought the 1956 construction total then to \$758,439,991. Of the current 92 projects, 28 are new hospitals and 56 are additions to existing facilities.

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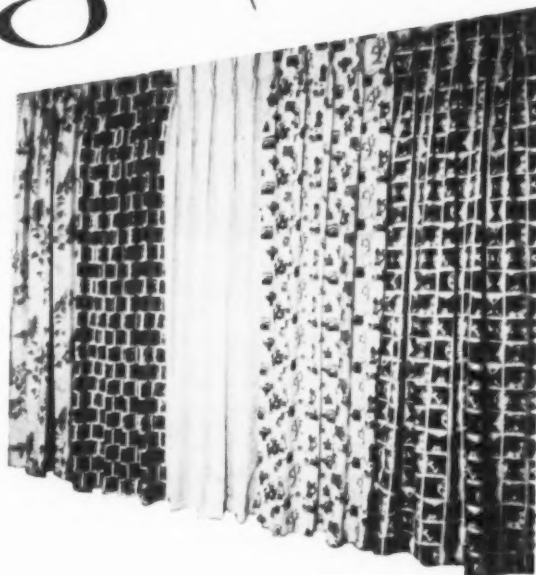
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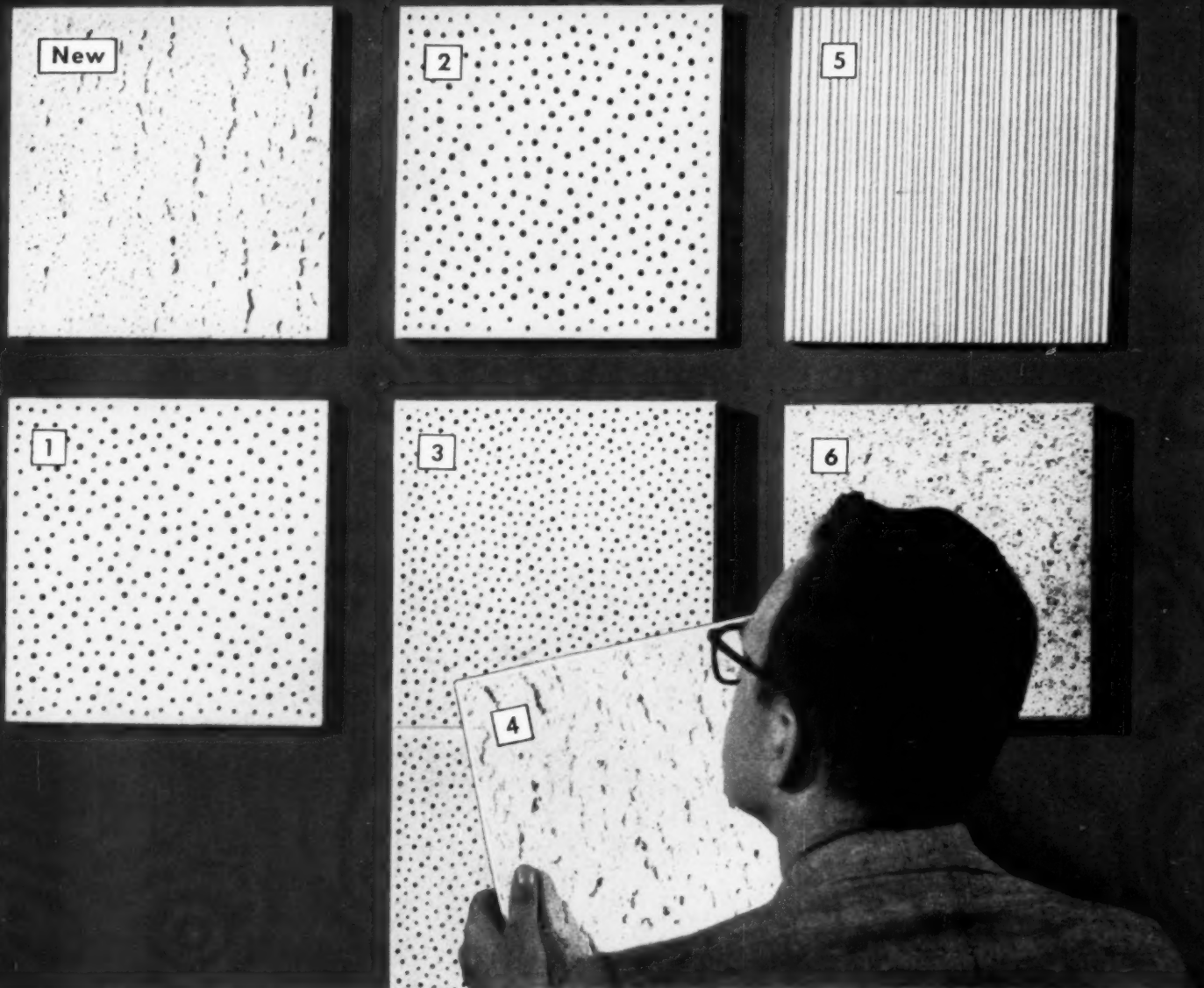
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ways. These extra features can provide a big return on the cost of sound conditioning.

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CLINIC MANAGER — Mid-west or west; 7 years office manager and assistant business manager of large hospital; MBA degree, broad experience and knowledge of accounting, purchasing, personnel, and administration; age 37; excellent references from present employer. Apply MW 211, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

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WOODWARD—Continued

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ADMINISTRATOR — Medical; 4 years, assistant director, 800-bed university hospital; 12 years, director, 400-bed teaching hospital; FACHA.

ADMINISTRATOR — M.H.A.; four years, associate director, teaching hospital, assisting in building program increasing capacity from 200 to 400; six years, director, 225-bed hospital.

ASSISTANT — B.S. (Business Administration); M.H.A.; since completing residency, teaching hospital, has served as its personnel director, lecturer and coordinator, Program in Hospital Administration.

ADMINISTRATOR — Professional nurse; graduate, university hospital school of nursing; B.S. (Education); M.S. (Hospital Administration); six years' teaching experience before specializing; two years, administrator, 150-bed hospital.

COMPTROLLER — B.S. (Major: Accounting); since 1951, comptroller and office manager, 210-bed hospital.

PATHOLOGIST — Diplomate; FACP; eight years, director of pathology, 350-bed general hospital, consultant to several others.

RADIOLOGIST — University hospital training in radiology including radioisotopes; M.S. (Radiology); four years, group association; Diplomate (Diagnostic and Therapeutic Radiology).

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR — Degree Business Administration; MACHA; 6 years experience, 200-bed hospital, east, administrator; available for appointment.

(Continued on page 160)

INTERSTATE—Continued

ADMINISTRATOR — Age, 38; B.S. Degree, Hospital Administration, Northwestern University; 8 years experience, 100-175 bed general hospitals; mid-west.

ASSISTANT ADMINISTRATOR — Age, 36 years; B.B.A., M.S. Degree in Hospital Administration; 2 years assistant administrator, 300-bed eastern hospital; previous experience in public accounting.

ASSISTANT ADMINISTRATOR — B.S. Degree, Hospital Administration; 12 years experience, western hospitals; large hospital preferred; excellent references.

PERSONNEL MANAGER — B.A. Degree, large Ohio university; 3 years present position, 400-bed hospital; will consider west and southwest.

EXECUTIVE HOUSEKEEPER — College credits; 1 year's training, 2 years experience as assistant to well known housekeeper, east; previous business experience.

EXECUTIVE HOUSEKEEPER — Degree; completed course Institutional Management; 3 years, 200-bed hospital, west.

POSITIONS OPEN

ADMINISTRATOR — Hospital; combined with chief nurse, or X-ray technician or laboratory technician, or other, needed for new 16-bed hospital to open early fall, 1958 at Grand Marais, Minnesota; small community, superior sports, fishing, hunting, skiing, good schools, low cost of living; salary open. Write Sherman Benson, President, Hospital Board, Grand Marais, Minnesota.

SUPERINTENDENT — For 35-bed hospital, duties to commence November 1, 1957; complete staff at present time. Apply stating references, age, experience and salary expected, to C. O. Monroe, Secretary-Treasurer, County of Bruce General Hospital, Walkerton, Ontario.

ANESTHETIST — Nurse; immediate opening; 40 hour week; 5% increase after six months; after one year, two weeks vacation with pay. Apply MO 207, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

ANESTHETIST — Wanted by fully accredited rural hospital; southwest; F.A.C.S. surgeon; ideal location for nurse who likes small towns; general surgery; and OB, rare emergency calls; salary open. Write or wire MO 209, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST — Nurse; for new 48-bed fully accredited hospital in central Massachusetts; total area served 21,000 population; expansion to minimum of 64-beds in planning stages. Apply MO 212, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST — Registered nurse; experienced to complete staff of 3 serving 2 hospitals 16 miles apart; however, applicant will work primarily in 71-bed fully accredited air-conditioned hospital; hospital currently expanding to 135-beds; starting salary of \$550 per month with liberal personnel policies; normal work week of 44 hours; hospital located in university city of 21,000. Write Jack B. Edmundson, Administrator, Doctors Hospital, Carbondale, Illinois.

classified advertising

POSITIONS OPEN

ANESTHESIOLOGIST—For community serving area of 21,000 in central Massachusetts; opportunity for practicing general medicine exists; combination of anesthesia and general medicine if desired. Apply MO 211, The Modern Hospital, 919 N. Michigan Ave., Chicago 11, Illinois.

ANESTHETIST—Nurse; excellent working conditions; \$450.00 per month with annual increases of \$25.00 per month to maximum of \$500.00; three weeks vacation after one year; minimum of two weeks sick leave; usual employee benefits; Lexington is located in "The Heart of the Bluegrass" famous for horse racing and tobacco industries, home of University of Kentucky and Transylvania College. Apply Assistant Administrator, Good Samaritan Hospital, South Limestone Street, Lexington, Kentucky.

ANESTHETIST—Nurse; position open in 134-bed general hospital; salary and living conditions very desirable; room, laundry and insurance benefits furnished in addition to salary; location on the east side of St. Paul with convenient transportation to the downtown area; two other anesthetists on duty with a minimum amount of call. Write E. M. Garnett, Superintendent, Mounds Park Hospital, 200 Earl Street, St. Paul 6, Minnesota.

ANESTHETIST—Nurse; full time or relief, for 50-bed hospital in lively resort area; excellent working conditions and reasonable salary. Apply Administrator, Memorial Hospital, North Conway, New Hampshire.

ANESTHETIST—Nurse; female; good salary, liberal fringe benefits; good hours; accredited 58-bed hospital. Apply to Superintendent of Allen Memorial Hospital, Oberlin College, Oberlin, Ohio.

ANESTHETIST—Nurse; female; excellent starting salary, merit increases, liberal fringe benefits, good hours; accredited hospital and surgeons limited to our staff. Apply to Elmer J. Berg, Business Manager, Gundersen Clinic, La Crosse, Wisconsin.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; good starting salary. Write Mr. Bert Stajich, Assistant Administrator, Columbia Hospital, 3321 N. Maryland Avenue, Milwaukee 11, Wisconsin.

ANESTHETISTS—Nurse; AANA members, \$400-\$475 per month; 400-bed general hospital excellent working conditions, liberal personnel policies; T.O., 16 anesthetists and one anesthesiologist. Write Personnel Director, The Queen's Hospital, P. O. Box 614, Honolulu 9, Hawaii.

ASSISTANT DIRECTOR—Medical records department; immediate opening; must be registered or eligible for registration; 446-bed general hospital; good salary and personnel policies; opportunity to work with professional activity study. Write Mr. J. M. Dunlop, Administrator, Bridgeport Hospital, Bridgeport, Connecticut.

ASSOCIATE DIRECTOR OF NURSING SERVICE—500-bed JCAH fully accredited general hospital, centrally located, near civic and cultural centers; school NLN full accredited; degree and successful nursing experience required. Apply Director of Nursing, Grace Hospital, Detroit 1, Michigan.

ASSOCIATE DIRECTOR OF NURSING SERVICE—For 600-bed JCAH accredited general hospital; degree and nursing administration

experience required; good personnel policies, salary open. Apply Director of Nursing, Harrisburg Hospital, Harrisburg, Pennsylvania.

DIETITIAN—Therapeutic; member of A.D.A.; five day week; salary open; modern well-equipped dietary department, newly built. Apply Administrator, St. Margaret's Hospital, Inc., 834 Adams Avenue, Montgomery 5, Alabama.

DIETITIAN—Therapeutic; Borgess Hospital, 340-bed general hospital; duties include cafeteria, therapeutic diet planning, patient contact, general supervising and teaching student nurses; a large full-time medical staff and house staff; salary open, progressive personnel policies. Apply Hospital Administrator, Borgess Hospital, Kalamazoo, Michigan.

DIETITIANS—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at \$300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross, Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIANS—ADA preferred, ADA eligible acceptable; can complete training while earning; salary open. Apply Director, The Buffalo General Hospital, Buffalo 3, New York.

DIETITIAN—If you are ready to take over as head of the department and are looking for an unusual and challenging opportunity we would like to hear from you; we are a 250-bed general community hospital soon enlarging to 500-beds; starting salary is \$6,000; four weeks vacation. Write or phone collect to Mr. E. C. Pohlman, Administrator, Grant Hospital, Columbus 15, Ohio.

DIETITIAN—Therapeutic; A.D.A. member, to supervise tray service, dietary personnel and counsel patients; no teaching required; hospital recently expanded to 450-beds, located in desirable residential district; approved by Joint Commission; dietary facilities entirely new and air conditioned; dietetic program integrated with approved school of nursing, affiliated with Medical Research Institute; 40 hour week, broad personnel policies and benefits; salary open. Apply Miss Rosemary E. Brown, Director of Dietetics, The Toledo Hospital, Toledo 6, Ohio, or call Greenwood 2-1121.

DIETITIAN—Assistant; 150-bed general hospital; excellent opportunity to gain therapeutic and administrative experience; salary open; liberal personnel policies. Apply Administrator, Yakima Valley Memorial Hospital, Yakima, Washington.

DIRECTOR OF EDUCATION—NLN accredited diploma school; basic sciences taught Amarillo College; total enrollment 100; forty hour week, salary commensurate with qualifications; hospital JCAH; 230-beds; expansion program in process, city population 150,000. Apply Mrs. Wanda Reed, Northwest Texas Hospital, Amarillo, Texas.

DIRECTOR OF NURSING—Excellent opportunity to demonstrate your ability and use initiative directing activities of a large nursing service in a modern 600-bed general hospital; salary \$7,944 with increases to \$9,487. Apply Flint Civil Service Commission, City Hall, Flint, Michigan.

DIRECTOR OF NURSES—50-bed general hospital now constructing 32-bed addition with all services for entire hospital requires immediately director of nurses with ability to

organize new departments, salary open, retirement plan. Apply Administrator, Elko General Hospital, Elko, Nevada.

DIRECTOR OF NURSING—Bismarck Hospital, Bismarck, North Dakota; 175-beds; must have degree in nursing education and nursing service; salary open; Protestant hospital. Apply to H. J. Bischof, President Board of Trustees, Bismarck Hospital, Bismarck, North Dakota.

DIRECTOR OF NURSING—Progressive 100-bed JCAH approved pediatric hospital with accredited pediatric residency training program and affiliated 20-bed adult rehabilitation program; starting salary dependent upon academic qualifications and experience, liberal sick leave, holidays, paid vacation policies. Write Administrator, Kauaikeolani Children's Hospital, 226 North Kuakini Street, Honolulu 17, Hawaii.

HOUSEKEEPER—Executive, 350-bed hospital located in desirable eastern resort area has an immediate opening; person we are seeking must have knowledge of work simplification, housekeeping standards and employee training; 55 in department; excellent opportunity for executive housekeeper in smaller hospital seeking advancement. Apply MO 210, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

INSTRUCTOR—Obstetric nursing; in a fully accredited school of nursing; 170 students, 350-bed hospital in large metropolitan city with educational and cultural advantages, college affiliation, housing available; liberal personnel policies; salary open. Apply MO 180, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

INSTRUCTORS—Clinical; for operating room technique and in medical and surgical nursing, day, evening and night shifts; integrated program; affiliated with Drake University; 200 students in school; 400-bed, fully approved, non-profit hospital; minimum qualifications: B.S. degree, preferably in nursing education; salary open, 40 hour work week; 20 working days vacation; sick benefits; position open immediately. Apply Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

INSTRUCTOR—Clinical-psychiatric nursing, for our affiliate psychiatric school of nursing, BS degree in Nursing Education, post graduate preparation in psychiatric nursing, ability to supervise and to teach nurses and aides in clinical area; salary open, 40 hour week with excellent benefits. Write to Personnel Supervisor, State Hospital, Jamestown, North Dakota.

INSTRUCTOR—Clinical; operating room; NLN accredited diploma school; assist operating room supervisor and teach formal and clinical classes for professional students; salary commensurate with qualifications; 40 hour week. Apply Mrs. Wanda Reed, Northwest Texas Hospital, Box 1110, Amarillo, Texas.

LIBRARIAN—Medical record; with demonstrated successful experience to serve as chief of department for 400-bed non-profit accredited teaching hospital which includes 115-bed pediatric unit; desire person capable of taking over current department with able assistants and with ability to supervise personnel and organize paper work flow and to adjust departmental work loads. Apply Personnel Director, Iowa Methodist Hospital, Des Moines, Iowa—friendly capital city of Iowa which includes campus of Drake University.

LIBRARIAN—Medical record; registered to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

(Continued on page 162)

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Gelatin causes at low temperatures. Warming to room temperature or above will restore the fluid state. Gelatin interferes temporarily with the typing of blood. If blood is to be typed, it should be done before administering the infusion. The fluid contained in this bottle should be used immediately after breaking the seal. Any unused portion should be discarded.

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POSITIONS OPEN

NURSES—Graduate staff; for full and part time positions; 147-bed hospital with school of nursing, situated 100 miles from New York; beginning salary ranging from \$265-\$270 to \$300, evening duty bonus \$20, night duty bonus \$30, operating room call bonus \$15, paid vacation and sick leave, full maintenance available. Apply Director of Nursing, Southampton Hospital, Southampton, New York.

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 days week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport—Capital 7-5195.

NURSING—Staff; annually \$3000 to \$3360 plus two meals daily and uniform laundry, six paid holidays, liberal sick leave and vacation. Apply Director of Nursing, Episcopal Eye, Ear and Throat Hospital, 1147 15th St., N.W., Washington 5, D.C.

NURSES—Staff; staff positions in all clinical areas including psychiatry, poliomyelitis and respiratory center in new, 800-bed air conditioned hospital; 40 hour week; 3 weeks vacation annually; beginning salary; staff nurses, \$275 monthly; periodic increments; opportunity for college study through bachelor's degree program. Write Director of Nursing Service, Eugene Talmadge Memorial Hospital, Medical College of Georgia, Augusta, Georgia.

NURSES—Registered; for staff duty in all departments; 674-bed general hospital located in industrial city (500,000 population); liberal personnel policies; 40 hour work week. For further information please apply to Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature experienced; \$3,000 per year, board, room and laundry available at \$480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSES—Registered general duty; for 50-bed general hospital; good working and living conditions; ideal climate; starting salary \$280 per month. Apply to W. R. Coe Memorial Hospital, Cody, Wyoming.

PATHOLOGIST—Associate; 434-bed, fully approved hospital, with residency programme; four weeks' annual vacation, five day week, sick benefits, etc.; salary commensurate with qualifications and experience; please reply fully, giving training, experience, nationality, age, etc., to Secretary, Board of Directors, Royal Columbian Hospital, New Westminster, British Columbia, Canada.

PHARMACIST—Assistant; eligible for licensure in New Jersey; 350-bed hospital. Write George A. Miller, Administrative Assistant, Monmouth

Memorial Hospital, Third and Pavilion Avenues, Long Branch, New Jersey.

SUPERVISOR—Assistant; in operating rooms; 300-bed hospital; adequate, modern equipment; 40 hour week, 20 paid days vacation, cash salary; liberal personnel policies; preparation and experience desired; salary open. Apply, Director of Nursing, Mercer Hospital, Trenton, New Jersey.

SUPERVISOR—Pediatric; for morning and afternoon; 100-bed children's convalescent hospital; degree preferred, experience necessary; paid vacation, sick leave, social security and retirement plan; salary dependent upon qualifications \$3800 to \$5000. Apply to Director of Nursing Service, Convalescent Hospital for Children, Cincinnati 19, Ohio.

SUPERVISOR—Operating room; NLN accredited diploma school; 230-bed general hospital; average 20 operations daily; 40 hour week, salary commensurate with qualifications. Apply Mrs. Wanda Reed, Northwest Texas Hospital, Box 1119, Amarillo, Texas.

TECHNOLOGIST—Laboratory; 250-bed hospital; salary open. Apply MO 171, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

TECHNOLOGIST—Medical; TB Sanatorium near Duluth, Minnesota; quarters, hospitalization, sick leave, retirement benefits; no call duty; A.S.C.P. registration required. Write Superintendent, Nopeming Sanatorium, Nopeming, Minnesota.

TECHNICIAN—Laboratory; 236-bed general hospital 30 miles from New York City; interesting position with advancement in progressive hospital. Contact Personnel Office, Morristown Memorial Hospital, Morristown, New Jersey.

TECHNOLOGISTS—Medical registered 160-bed general hospital, college town, 20 miles west of Milwaukee, major expansion program including new department of laboratory medicine started in spring of 1957; affiliation with Carroll College for training of medical technologists now in development stage; full time pathologist. Apply Personnel Department, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

TECHNICIAN—Laboratory and X-ray; for small hospital in Wyoming; 5 day week subject to call every other week; must be willing to help in record room and office; salary depending on qualifications and ability. Apply Administrator, St. John's Hospital, Jackson, Wyoming.



The Medical Bureau

M. BURINCE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 NORTH MICHIGAN AVENUE CHICAGO

ADMINISTRATOR—(a) Medical; 425-bed general hospital, unit of hospital group; east. (b) Director, voluntary general hospital, 200 beds; building program will increase to 300; college town, midwest. (c) Young administrator; new general hospital, 50-beds; California. (d) Assistant; 200-bed general hospital, principal teaching facility of university medical school; east. (e) Assistant administrator; preferably one with accounting background and experience which would qualify him for administrative advancement; 175-bed general hospital; building program; medical center, east. (f) Assistant administrator qualified to combine duties with those of controller; 300-bed general hospital; college town, east; \$8000; MH11-1

(Continued on page 164)

MEDICAL BUREAU—Continued

ANESTHETISTS—(a) Florida, summer, winter resort, large hospital, one obstetrical, one surgical, top area salary. (b) Nurse anesthetist, complete staff M.D. group, metropolitan New York City. (c) Complete responsibility, 50-bed hospital; Illinois; \$7200. (d) Anesthetist, work between two hospitals; wealthy cattle ranch area near Canadian border; good salary potential. MH11-2

DIETITIANS—(a) Chief, 400-bed hospital, 8 dietitians on staff; midwest; \$7000. (b) Chief, large hospital, Greater New York; \$5500. MH11-3

DIRECTORS OF NURSING—(a) Director, nurses; responsible school, service, college affiliations; 400-beds; commuting distance, New York City; \$10,000. (b) Director, nursing service, 275-bed hospital, beautiful old Southern city; \$7500. (c) Director, nursing service, school; 350-bed hospital, expansion program to 400; 350 students; ideal mid-west city; \$8000 up. (d) Director of nurses strong administrative background; reorganize staff 600 nurses, all graduate; 500-bed hospital; West Coast; to \$12,000. MH11-4

EXECUTIVE HOUSEKEEPER—Top notch administrative ability required; reorganize staff of 500-bed hospital; California; to \$7200. MH11-5

EXECUTIVE PERSONNEL—(a) Accountant qualified to direct business office; new 80-bed general hospital building program will double capacity; Florida. (b) Purchasing agent; preferably course graduate; 300-bed voluntary general hospital; California. (c) Business manager; preferably course graduate with experience in accounting; 450-bed general hospital; east. (d) Personnel director qualified to organize department; 300-bed general hospital; near Chicago. (e) Controller and purchasing agent, both with hospital experience; 350-bed hospital, university city; east. (f) Public relations director by hospital council consisting of hospitals totaling 18,000 beds; broad experience in community planning required. (g) Food service director; new position, 400-bed hospital; midwest; \$7000. MH11-6

FACULTY POSTS—(a) Assistant professor, medical-surgical; collegiate school; academic year; \$520 month; east. (b) Operating room clinical instructor 270-bed hospital, 100 students; beautiful town, 7000, Pennsylvania; \$5400. (c) Operating room, overseas assignment; American owned company, paid transportation, \$10,000. (d) Research assistant; reevaluate procedures; set up new program; 900-bed hospital; university center; leading city; \$6000. MH11-7

MEDICAL RECORD LIBRARIANS—(a) Chief; university teaching hospital, 900-beds; excellent research opportunity; midwest. (b) Director-instructor; school for medical records librarians; progressive city, southwest. (c) Chief; top-notch person; reorganize department, large well renowned hospital; West Coast; \$7200. MH11-8

SUPERVISORS—(a) Operating room, central supply; foreign assignment; American owned company hospital; paid air travel; \$10,000. (b) Obstetrics; South America, Spanish desirable; \$7000. (c) General supervisor, exclusive home retired persons; beautiful country atmosphere, grounds; near leading Midwestern city; \$350, complete maintenance. (d) Emergency room; capable person for busy department; 200-bed hospital; Florida resort; salary commensurate ability. MH11-9

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WOODWARD—Continued

opportunity achieve directorship; requires at least nominee ACHA; southern California. (k) 2 new units, general acute hospitals, 125-beds; range \$10-15,000; large city; mid-east. (l) Children's medical center; several units housed in 50-bed approved hospital; south.

ASSISTANT ADMINISTRATORS—(m) To work directly under and report to FACHA, 1st year; then, assist administrator with own responsibilities; 200-bed hospital; university town; New England. (n) Assistant, short time, then associate director; children's hospital, 200-beds; will succeed present director upon retirement; university city; West Mountain State. (o) Qualified to assume administrative function in absence of director; fairly large voluntary general hospital; near Pittsburgh. (p) Voluntary, general hospital, fairly large size; large town, vicinity Detroit. (q) 225-bed, general, voluntary hospital; teaching program; about \$8,000; large city on Lake Michigan.

CLINIC MANAGER—(r) 8-man group of doctors, various specialties; in future may venture into building program; about \$500 a month, depending on qualifications; increases periodically; West Coast.

EXECUTIVE HOUSEKEEPERS—(s) Male only; to assume full charge department, very large general hospital affiliated university medical school; requires experienced, capable man; able establish new methods, procedures and training programs; east. (t) Outstanding

WOODWARD—Continued

large university hospital; well situated in attractive residential area, important southeastern university center. (u) Supervise staff of 65 in busy department, 550-bed general hospital now expanding; college city 100,000; east. (v) Staff of 50 in department, very large fully approved general hospital; ideal location, Pacific Northwest. (w) Approved 100-bed pediatric hospital; salary plus 3-room apartment; New York City vicinity.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—(a) 200-bed hospital, New England. (b) 145-bed hospital, east; \$12,000. (c) 50-bed hospitals, New York, Pennsylvania, Ohio, Iowa, Missouri. (d) Assistant, 200-bed eastern hospital. (e) Purchasing agent, 400-bed hospital.

PERSONNEL DIRECTOR—200-bed hospital, east.

BUSINESS MANAGER—(a) 140-bed hospital, east. (b) 200-bed hospital; Pennsylvania. (c) Small private hospital, mid-west. (d) 65-bed hospital, Ohio.

(Continued on page 166)



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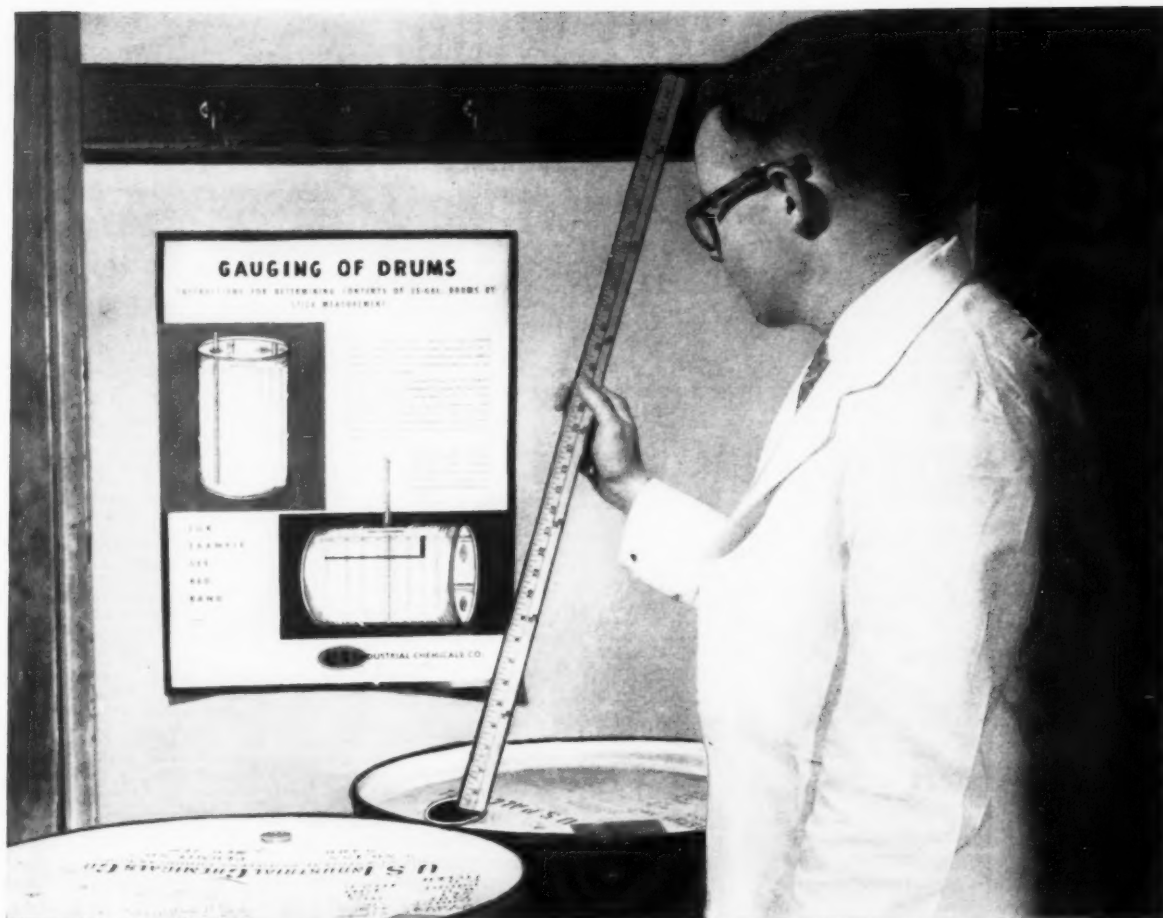
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MEDICAL RECORD LIBRARIANS—To \$6000.

EXECUTIVE HOUSEKEEPERS—(a) 400-bed hospital, central state. (b) 300-bed eastern hospital. (c) 120-bed hospital, south. (d) 250-bed Ohio hospital; building program; \$500.

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SHAY—Continued

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MEDICAL RECORD LIBRARIANS—(a) Southeast; large teaching hospital; \$5500. (b) Chief; south; 100-bed hospital; 3 in department; \$350 plus maintenance. (c) Chief; middle west; 350-bed hospital; 14 employees in department; \$6000. (d) Chief; east; supervise and develop program in 250-bed teaching hospital; \$5200. (e) Chief and instructor in approved school for record librarians; 350-bed hospital; degree required. (f) Chief; Pacific northwest; 2 assistants; standard nomenclature; dictaphone record system; 125-bed hospital.

DIETITIANS—(a) Chief; south; 8 in department; supervise and do all purchasing; 125-bed hospital; \$4800 plus complete maintenance. (b) Middle west; 50-bed hospital expanding to 80-beds; good experience as assistant; \$5400. (c) Administrative; Middle west; 350-bed hospital to \$5400. (d) Food, service manager; supervise entire food service in 260-bed teaching hospital; to \$6500. (e) Therapeutic; east; supervise special diets kitchen; \$400 minimum. (f) Chief; east; 250-bed hospital—will be 500 in another year; 3 well qualified assistants; to \$6000.

(Continued on page 168)

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ADMINISTRATOR—(a) 200-bed eastern hospital, JACH approved, salary \$15,000. (b) 100-bed eastern JACH approved hospital; salary open. (c) 120-bed hospital; JACH approved, salary open, east. (d) 50-bed new hospital; resort area, southeast, salary open. (e) 100-bed hospital, new, west; salary open. (f) 50-bed hospital; Montana, salary \$8,000. (g) 100-bed hospital; Missouri, salary open. (h) 50-bed hospital; Kansas, salary \$6500. (i) 100-bed hospital; south, now under construction, salary open.

ASSISTANT ADMINISTRATORS—(a) 300-bed university hospital; northeast; salary open. (b) 200-bed hospital; Massachusetts; salary open. (c) 250-bed hospital; Massachusetts; would like an applicant who is willing to spend 3 years studying all departments of hospital. B.S. Degree required. (d) Assistant administrator charge of methods and improvements, Massachusetts. (e) Large 300-bed hospital; south. (f) 200-bed hospital; Ohio, must be a good accountant. (g) 200-bed hospital; Texas.

BUSINESS MANAGERS—(a) Large 200-bed hospital; Ohio, salary open. 267-bed hospital; Massachusetts; salary \$6000. (c) 200-bed hospital; Florida; salary open. (d) 200-bed hospital;



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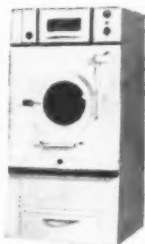
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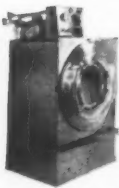
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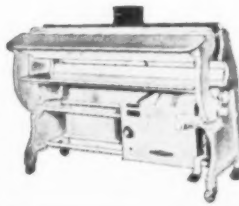
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X-RAY TECHNICIANS—(a) Texas, must be R.T., salary \$350 to \$400 per month. (b) Illinois 100-bed hospital. Salary \$350 per month. (c) Chief Technician; to take over school; Illinois; salary open.

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(Continued on page 170)

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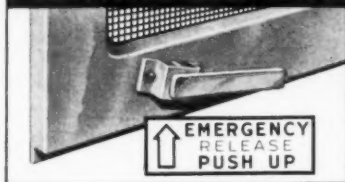
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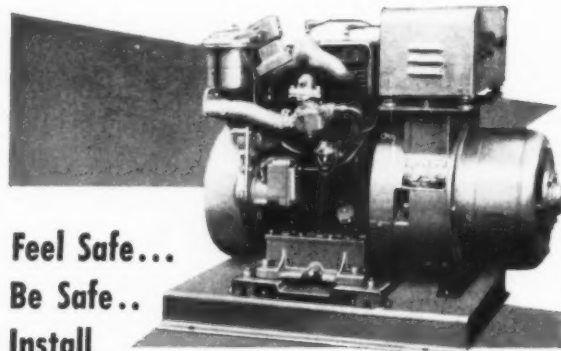
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(Continued on page 174)

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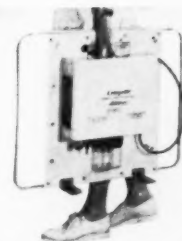


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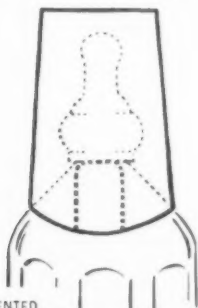
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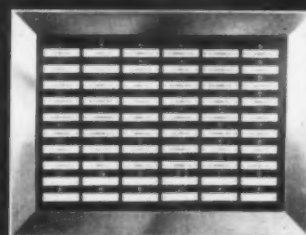
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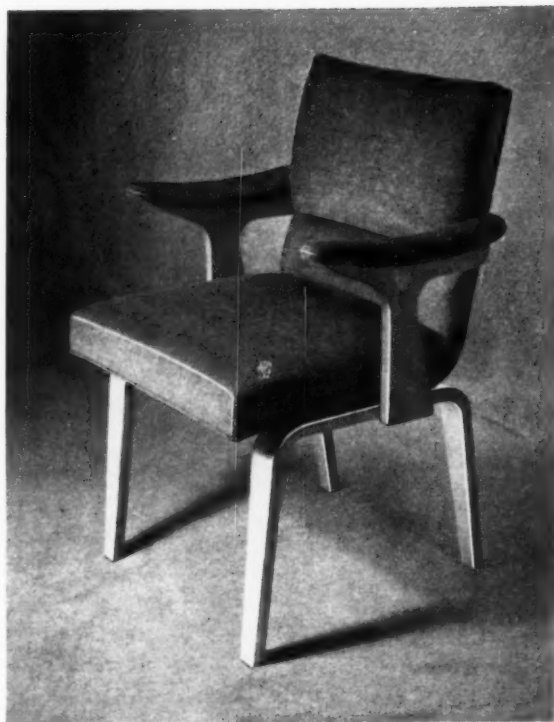
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STANLEY R. CLAGUE, Business Manager.

Sworn to and subscribed before me this 28th day of September, 1957.

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(My commission expires Sept. 29, 1961)



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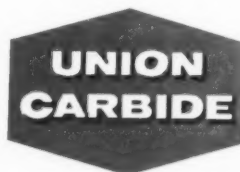
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WHAT'S NEW FOR HOSPITALS

NOVEMBER 1957

Edited by BESSIE COVERT

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 204. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Electronic System

Controls Temperature Remotely

Temperatures in the operating room, nursery, obstetrical department and psychi-



atric detention rooms, as well as in other areas of the hospital, can now be adjusted by remote control. With a foot pedal beneath the operating table, the surgeon signals a nurse at the supervisory desk, remote from the surgery. A sensitive microphone picks up his voice as he indicates the temperature change desired. By pushing a button on a control panel and reading an indicator in front of her, the supervisory nurse can make the desired change instantly. Temperature is reset by turning a calibrated knob.

Known as the Hospital-Master, the electronic system permits remote control of heating and air conditioning. The supervisory nurse sits at a desk with a five-foot panel containing push buttons, indicating lights, knobs and a telephone. Normal intercommunication between the surgery and the supervisory nurse is integrated with the panel. Temperature changes can be made without delay with the Hospital-Master system, not only in the surgery and other special areas, but also in individual rooms if desired. The system also provides communication with patients. Other control functions can be incorporated into the Hospital-Master, including fire alarm, low room humidity alarm, low or high room temperature alarm, room lighting control, passive bed signal and other controls. Minneapolis-Honeywell Regulator Co., 2820 Fourth Ave. S., Minneapolis 8, Minn.

For more details circle #939 on mailing card.

Standard Typewriter

Features Lighter Touch

The new Underwood Touch-Master Standard Typewriter has been specifically designed to ease the typist's work load. Research showed that lighter touch was the number one improvement desired and the Touch-Master now requires up to 26 per cent less typing effort. Major design changes save 350 foot pounds of energy in an average typing day, according to the manufacturer. The Touch-Master is avail-

able in Caribbean Green, Beach Beige and Continental Gray in the popular crackle finish. The Underwood Corporation, 1 Park Ave., New York 16.

For more details circle #940 on mailing card.

Disposable Syringe

Complete With Needle

Economical in price, the new Safti-Syringes are made of disposable plastic and supplied sterile and complete with needle. They are available in all common sizes with the price depending upon the size and quantity purchased. Designed to eliminate the possibility of cross-infection and the time and effort of cleaning and sterilization, the Safti-Syringe is packaged in an individual, airtight container with factory-sharp needles for patient comfort. Chicago Apparatus Co., 1735 N. Ashland Ave., Chicago 22.

For more details circle #941 on mailing card.

Touch-n-Go Foodveyor

Has Motorized Propulsion



A self-powered food conveyor that moves slowly and safely at the touch of a button is available in the new Blickman Touch-n-Go Foodveyor. An integral battery-powered motor drives the fully loaded conveyor at approximately two miles per hour forward and one-half mile per hour in reverse. A loaded conveyor will move up or down a rise of one foot in twenty under complete control. The Foodveyor is designed to maneuver in narrow areas, to fit into all standard elevators, and the caster arrangement permits a complete turn within a 78-inch circle. The power drive requires no accessory equipment and the battery is charged in daily operation as the conveyor is being pre-heated or pre-cooled.

In operation the Foodveyor moves slowly when the button on the end of the steering handle is depressed and stops instantly when pressure is removed. The operator walks ahead of the unit, steering it by turning the handle in the desired direction. Another control button is pressed for re-

verse. Manual operation can be accomplished if desired. Larger capacities are possible with the motorized unit as weight is not a problem. Motorization permits easy handling of even the heaviest unit by the smallest female employee. Thus less labor is required and meal distribution is speeded, while fewer units are needed for serving large areas.

The new Foodveyor has a variable capacity from 18 to 24 meals with a fully insulated, thermostatically controlled heated compartment and a refrigeration system for the cold compartment. Both compartments have removable interiors for easy cleaning. The overall size of the Touch-n-Go Foodveyor is 29½ inches wide, 78 inches long, with a working height of approximately 49 inches. S. Blickman, Inc., Weehawken, N.J.

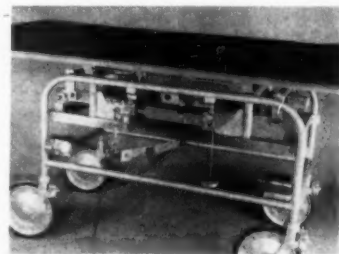
For more details circle #942 on mailing card.

Weighing Stretcher

for Accurate Patient Weight

Daily body weights of patients can now be accurately recorded with the new Model 1198 weighing stretcher. The scale, mounted to the under-chassis by a carefully engineered frame, is calibrated to ensure highest possible accuracy, without the necessity of careful positioning of the patient. Weights can be measured either in pounds, in two-ounce graduations, or in kilos, in 50 gram graduations. The two bars permit adjustment to balance the tare, including the stretcher pad and draw sheet or blanket, before the patient is transferred to the litter top, thus giving accurate daily changes in body weight.

The basic standard tubular chassis of the stretcher is modified to allow the mounting of the scale. The balance of the stretcher includes the standard litter top which accommodates the standard two-inch conductive foam rubber pad. The entire stretcher is mounted on four dual control casters which can be locked in an immovable position when the patient is being weighed. The Model 1198 Weighing



Stretcher is constructed of carbon steel with baked-on gray enamel finish. Scale beam, poise and weights are of brass with either nickel or chrome plating. Jarvis & Jarvis, Inc., Palmer, Mass.

For more details circle #943 on mailing card.

(Continued on page 178)

WHAT'S NEW

Deknatel Plastic Pak Reduces Suture Handling

The new transparent Deknatel Plastic Pak is a safety sealed, sterile suture pack.



Suture handling is reduced to a minimum as the Pak is inverted after a simple,

straight-across cut, and the suture slides out freely without assistance. The same sterilizing solution as used with glass containers is employed and the sterility technique for sutures is unchanged. The hazards of broken glass are eliminated with the Plastic Pak and unopened Paks can be resterilized. J. A. Deknatel & Son, Inc., 96-20 222nd St., Queens Village 29, L.I., N.Y.

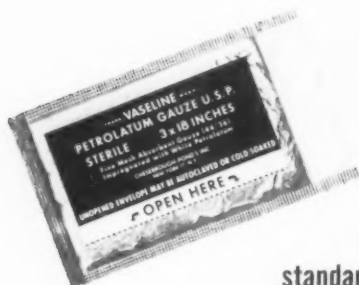
For more details circle #944 on mailing card.

High Humidity Oxygen Tent Is Easily Cleaned

High humidity and easy cleaning are two outstanding features of the new #1150 Aquator Tent. A nebulizer, readily accessible from the top of the cabinet, will pro-

vide humidity up to 100 per cent. Two oxygen flowmeters are provided on the control panel, one supplying oxygen to the nebulizer and the other direct to the tent canopy. Thus any desired condensation can be produced in the cabinet together with the desired humidity. Condensation inside the canopy is reduced to a minimum since the liquid receiver supplying humidity is pre-cooled, due to its location in contact with the cooling coils.

An easily removable door on top of the cabinet permits the cleaning of the re-



VASELINE® PETROLATUM GAUZE

conforms fully to the official
standards prescribed by the U.S.P.

This prepacked, pretested material assures unquestionable sterility at time of use.

Especially-designed equipment impregnates the gauze so lightly and uniformly that the danger of maceration is minimized.

Most hospitals are neither staffed nor equipped to follow the U.S.P. XV specifications for the preparation and control testing of a dependably sterile petrolatum gauze. That is why 'Vaseline' Sterile Petrolatum Gauze U.S.P. is their choice of a nonadherent dressing. It has proved itself "best by test" in millions of cases in thousands of civilian as well as military hospitals throughout the United States.

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frigeration coil with a hose or other device. The wash water is rapidly carried off through the large volume drain provided. This unique feature permits easy cleaning of the tent after each use. These new features are also included in the standard oxygen tent model. McKesson Appliance Co., 2226 Ashland Ave., Toledo 10, Ohio.

For more details circle #945 on mailing card.

Steam Cooker Is Self-Generating

The Steam-Chef Model 3SF is a three-compartment, self-generating steam cooker. It is designed for use in institutional kitchens without adequate steam facilities and occupies less than ten square feet of floor space. The self-contained boiler is of special heavy duty design for rapid generation of steam and is available in either electric or gas-fired models.

The new model permits arrangements of pans or baskets in pairs or side-by-side for easier loading, unloading and inspection of food during the cooking cycle. The overall height of the cooker is only 67 inches, placing all three compartments within easy reach. Cleveland Range Co., 3333 Lakeside Ave., Cleveland 14, Ohio.

For more details circle #946 on mailing card.

Fitted Mattress Pad Has Sanforized Skirt

A Sanforized bleached skirt, tightly sewn to the binding with elastic tension to hold it firm, is an added feature of the Bates Colonial Mattress Pads. Style 1304 has all of the superior features of the Bates pad with the added advantage of the fitted skirt. It is made of fully bleached new white cotton, seamless and without filling. It is easy to launder, dries quickly, is easy to handle and clings to the mattress. Bates Fabrics, Inc., 112 W. 34th St., New York 1.

For more details circle #947 on mailing card.

(Continued on page 180)

"You mean I'll always get operating reports by the 10th?"



The administrator finds it hard to believe. The comptroller, on the other hand, *knows* it's true. Yes, he can now supply complete operating figures by the 10th of *every* month . . . can be certain that reports reach the board by the 15th.

What brought about the change? McBee Keysort punched-card controls! Keysort Requisition-Charge Tickets and Patient-Day Statistical Cards — speeded by the new, designed-for-hospitals Keysort Data Punch — have allowed this hospital to reduce paper work at nursing stations, increase handling efficiency in service departments,

ensure promptness and accuracy in posting charges. Result: Keysort now gives the administrator faster, more accurate and complete analysis of income. He can thus better evaluate service-department output and utilization of special services . . . determine true cost per patient day. He makes a complete report to the board . . . *on time*.

Learn how Keysort can today help you institute proper administrative controls by speeding to your desk the timely reports which make possible better patient care. The nearby McBee man can show you how it's done. Why not phone him, or write us?

MCBEE **KEYSORT**®

Better patient care through administrative controls

ROYAL MCBEE Corporation, Port Chester, N. Y.

Offices in principal cities. In Canada: The McBee Company, Ltd., 179 Bartley Drive, Toronto 16.

HELPS YOUR KITCHEN PASS RIGID SANITARY INSPECTIONS



NEW A-F "PANHANDLER" Ensures Clean, Sanitized Pans, Utensils, Food Transport Containers

More and more major hospitals are installing A-F "Panhandler" Pan and Utensil Washers . . . like this one in the kitchen of a large State Mental Institution . . . to be sure that their standards of cleanliness and sanitation are above reproach.

By virtually eliminating the factor of human error and substituting forceful, high-pressure spray action, the A-F "Panhandler" cleans quickly, thoroughly, uniformly. The operator simply loads, sets the dial and the machine does the rest — "wash-drain-rinse" — automatically. Most important, the A-F "Panhandler" operates at elevated temperatures to flash-dry as well as sanitize.

If you want your kitchens to pass the most rigid inspections . . . to wash pans, utensils and transport containers more efficiently and economically — write for new "Panhandler" catalog — today!



Versatile Model VP "Panhandler" washes a wide variety of items, including small, lightweight lids for food transport containers, shown here in racks for more efficient cleaning.

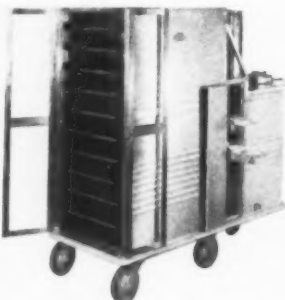
THE ALVEY-FERGUSON CO.

217 Disney Street, Cincinnati 9, Ohio
Representatives—Coast to Coast

WHAT'S NEW

"Mighty 28" Tray Cart Has Extra Capacity

Extra tray capacity in minimum space with easy cleaning are features of the new Mealpack "Mighty 28" Tray Cart. Designed to carry twenty-eight 16 by 22-inch trays, the increased capacity of the cart saves handling time, floor space and



personnel as well as cleaning costs. The compact unit is readily maneuvered in minimum space and may be quickly cleaned inside and out with a hose or other cleaning method as there are no electric wires or heating elements.

Mealpack "Freezishelves" which are pre-chilled in a freezing compartment assure cold protection of cold foods. Tray assembly is simple with the new cart and the transparent Lucite rear doors have piano hinges for folding back flush to the cart sides where they are held by magnets. This feature facilitates loading and unloading and keeps the doors out of the way of corridor traffic. The "Mighty 28" is constructed of durable, sanitary stainless steel throughout. It carries two seven-quart beverage dispensers, one five-quart food jar, one electric toaster and two pull-out Freezishelves. Mealpack Corporation, 2014 Ridge Ave., Evanston, Ill.

For more details circle #948 on mailing card.

Aren Identification Band Is Complete Unit

No tools are required to attach the new Aren patient Identification Bands. The pure white, non-toxic plastic bracelet is exceptionally strong and the tamperproof



snap fastener cannot be accidentally opened. Name and other necessary information are inserted under the crystal clear plastic window and the one-piece Aren band is adjusted as to size and the snap closed. The band cannot irritate and there are no sharp edges or corners. Available in adult and infant sizes, Aren Identification Bands can be used for all patients. Will Ross, Inc., 4285 N. Port Washington Rd., Milwaukee 12, Wis.

For more details circle #949 on mailing card.

(Continued on page 182)



ELECTRIC PLANT NEWS



Power outages can do no harm in this hospital

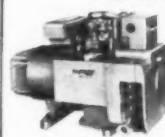
Onan Electric Plant supplies emergency power for lighting and all vital electrical equipment

An Onan Emergency Power System protects patients and personnel. Supplies current for lighting corridors, operating rooms, delivery rooms, stairways; provides power for heating system, ventilators, elevators, X-Ray machines, and other vital equipment.

Your hospital is assured of electric power at all times with Onan Emergency Electricity. Operation is completely automatic. When highline power is interrupted, the plant starts automatically; stops when power is restored.

Models for any size hospital—1,000 to 75,000 watts A.C.

Complete standby systems at lower cost



Onan Vacu-Flo cooling permits using air-cooled models in many installations at a considerable saving. Check Onan before you specify.

See your
architect or
engineer



Write for
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D.W. ONAN & SONS INC.
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*The
Strength
of Metal
Where You
Need It!*




From your oxygen flowmeters, you have the right to expect years of rugged service—without maintenance or delicate handling.

Puritan's handsome, chrome plated metal body shields the plastic calibrated flow tube from damage and assures the necessary strength required by daily use.

In Puritan Flowmeters, this time-tested design principle is combined with such unexcelled performance characteristics as:

- ... flow accuracy unaffected by back pressure.
- ... usable with every type of administering equipment.
- ... dependable readings under all conditions.
- ... easy to read and adjust.
- ... usable with Regulators or Piping Systems.

*You Pay
No More for the
Very Best When You
Insist on the*
**PURITAN
PRESSURE COMPENSATED
FLOWMETER**

Puritan 
COMPRESSED GAS CORPORATION
SINCE 1913
KANSAS CITY 8, MO.
PRODUCERS OF MEDICAL GASES
AND GAS THERAPY EQUIPMENT

WHAT'S NEW

Triangular Linen Hamper Saves Storage Space



Easy side-by-side storage saves space when the new Brewer triangular shaped

hospital linen hamper is not in use. In use it is easy to handle and the two large 10-inch rubber-tired wheels plus a single small front caster permit the hamper to be rolled easily over door sills or rough floors. The shape and the casters also permit tilting the hamper for pushing or pulling. Faster, easier movement with better control in close quarters is also possible. Constructed of tubular steel with Brewer-chrome heavy chrome plate, the hamper is available in two sizes: No. 1336, in which a smaller 18-inch hamper bag can be used, and No. 1346 for use with the standard 25-inch hamper bag. E. F. Brewer Co., Butler, Wis.

For more details circle #950 on mailing card.

Wall Suspended Ledges in Modular Furniture Line

Modular components and wall suspended ledges are features of a new line of hospital furniture developed for patient rooms, as well as for personnel housing. Built on an original design, the modular components are combined with easily installed wall suspended ledges, giving the appearance of custom built-in furniture while offering the economy and flexibility



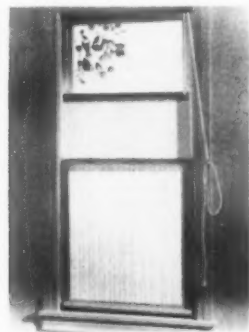
of non-permanent installation. Attached with heavy duty braces, the wall suspended ledges can be easily changed and moved.

Maximum protection and sanitation are offered with the new line which has front and top surfaces of self-edged laminated plastic. The plastic finish is offered in a wide variety of ash and walnut wood grains as well as solid colors, permitting full color coordination. Interior construction is of all metal with nylon rollers in all drawers for ease of opening and closing. Legs and hardware are chromium plated with satin finish. The new design is available in beds, dressers, overbed tables, bedside cabinets, nightstands, chests, desks, vanities, chairs and wall suspended ledges. Community Metal Products Corp., 1213 S. Circle Ave., Forest Park, Ill.

For more details circle #951 on mailing card.

Strathmore Window Shade Has Self-Woven Stripe

A self-woven stripe gives individuality and interest to the new Strathmore window shade manufactured by Joanna Western



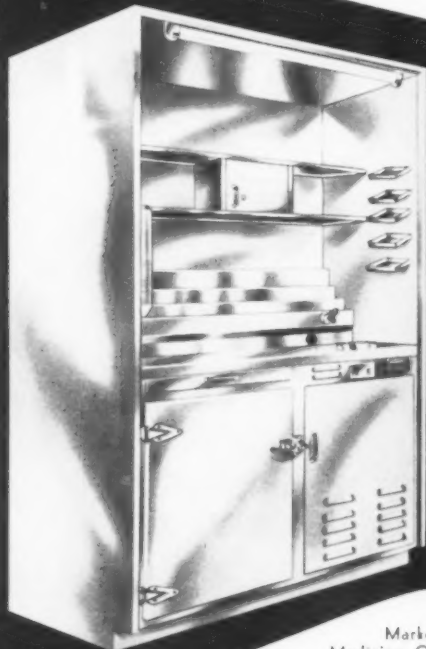
Mills Company of Chicago. Made of sturdy cloth with an invisible vinyl coating which makes it washable, rain-resistant and flameproof, the new window shade gives an attractive new look to windows in the hospital or the nurses' home. It is available in white and light beige in sizes up to 54 inches wide, mounted on a quiet, dependable roller. Window Shade Mfrs. Assn., 341 Madison Ave., New York 17.

For more details circle #952 on mailing card

(Continued on page 184)

NEW MARKET FORGE MEDI-PREP MEDICINE CABINET the PACKAGED SOLUTION

TO THE PROBLEMS OF STORING
PREPARING AND DISPENSING
OF MEDICINES



WITH THESE 14 FEATURES

- ◀ All Stainless Steel
- ◀ Fluorescent Lighting
- ◀ Narcotic Cabinet
- ◀ Storage Shelves
- ◀ Cup Dispenser
- ◀ Pill Box Shelves
- ◀ Medicine Shelves
- ◀ Water Faucet
- ◀ Sink
- ◀ Waste Facilities
- ◀ Work Counter
- ◀ Syringe Drawer
- ◀ Refrigerator
- ◀ To be used either recessed or free standing.

The new Market Forge Medi-Prep Medicine Cabinet is the result of extensive time and motion studies and provides a well-lighted counter and sink with easy-to-see and reach facilities for medicines, syringes, pills, narcotics and refrigerated biologicals. — Complete with a separate locked compartment for narcotics with a removable step rack and a built-in refrigerator with three sliding drawers. The new Medi-Prep provides an economical compact unit which results in substantial savings in nursing time and effort.

Every hospital, new or old, can gain the advantages of the new Market Forge Medi-Prep Medicine Cabinet.

Send today for detailed specification sheets on this new unit.



MARKET FORGE COMPANY
EVERETT, MASSACHUSETTS



now . . . for the first time . . .
two new oxygen-tent units that are

easy to wash!

McKesson AQUALORS

Just remove door on top. Then wash the coils with
hose or large volume of water!

Don't worry! Large-diameter drains
mean quick removal of wash-water.

A great convenience to service personnel.

Only McKesson Aqualors have this feature!

**100% HUMIDITY MAINTAINED
BY THIS MODEL 1150!**

Nebulizer is located in bellows-tube
connection. Easily removed by service
personnel.

STANDARD AQUALOR (Model
1155) is identical to Model 1150, ex-
cept for High-Humidity feature.

**Lighted
Control Panel**

note oxygen flowmeter
(center), temperature and
ventilation controls (left
and right), oxygen con-
trols (bottom).

McKesson

**AQUALOR
OXYGEN TENTS**

**for full
information**

write for McKesson
Aqualor Brochure!

McKesson APPLIANCE COMPANY • TOLEDO 10, OHIO

WHAT'S NEW

Thermal Beverage Server in Attractive Design



A practical, attractive design is offered in the new Windsor Pattern Thermal Beverage Server No. 8395. The thermal effi-

ciency of the server holds heat or cold for long periods. The new cover design facilitates one-hand pouring. The Windsor is made of highly polished stainless steel with unbreakable and sanitary welded interior. It is 5½ inches high, 5¾ inches wide, with a 2¾-inch mouth. Landers Frary & Clark, Stanley Division, New Britain, Conn.

For more details circle #953 on mailing card.

"Kangaroo" Floor Cleaner Has Tool Storage Area

A tool storage compartment built into the front of the tank on the new Hydro-Jet Vacuum Cleaner accounts for its title of "Kangaroo." Attachments for most gen-

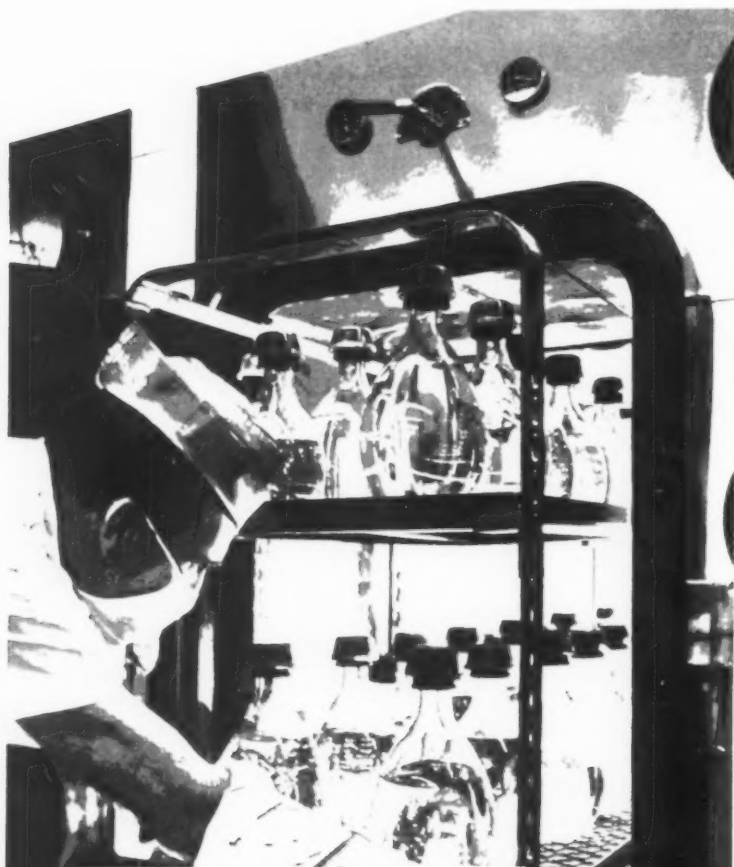
eral cleaning and maintenance operations are readily available with the machine which is designed for volume pick-up for either wet or dry materials. Available in two sizes, the SJ-105 has a five-gallon recoverable capacity and the SJ-108 will recover eight gallons. Both sizes have large rear wheels and handle for convenient transport.

Also new in the Hydro-Jet line is a heavy-duty model which will pick up 12 gallons of liquid or 1½ bushels of dry material. It features quiet operation with low



cost. It also has the square tank for added stability and strength as well as increased capacity. Advance Floor Machine Co., 4100 Washington Ave. N., Minneapolis 12, Minn.

For more details circle #954 on mailing card.



A Simpler, Safer Technique

Simplicity is the foundation of safe, sterile technique. And Castle's Thermatic System® is the simplest of all.

Through automation, a single master switch controls the complete sterile cycle, regardless of load or desired exposure. The operator sets the control, closes the safety door and the Thermatic System does the rest. It's that simple!

Thermatic processing is sterilization without the possibility of error, and that means greater safety for the patient.

Write for descriptive folder.

Castle

WILMOT CASTLE COMPANY
1700J East Henrietta Road • Rochester, N. Y.
LIGHTS AND STERILIZERS

Cancer Registry System Meets Accrediting Standards

Designed to meet minimum standards of the accrediting agencies, the new Cancer Registry System requires a minimum of time from the medical record librarian for maintenance. The system of standardized forms conforms to specifications in the "Manual of Cancer Registries and Cancer Clinical Activities" of the American College of Surgeons and provides complete and adequate records of cancer cases. The three basic elements of a cancer registration system are provided: a Cancer Accession Register; a means of indexing and filing the records, and a follow-up control. Physicians' Record Co., 161 W. Harrison St., Chicago 5.

For more details circle #955 on mailing card.

Permanent Germproofing With Wal-Shield Wall Finish

Air-Borne bacteria are said to be killed on coming into contact with Wal-Shield. Providing a decorating agent in soft, subtle colors, Wal-Shield is not only a protective coating but provides antiseptic qualities in walls and ceilings covered with it. Areas are germ proofed against a wide variety of bacteria and the report states that Wal-Shield retains its antiseptic properties during the long life of the product. It is available in soft pastel colors, dries quickly, is odor-free and easy to apply. The resulting finish is also washable and colors are fade-proof. M. A. Bruder & Sons, Inc., Philadelphia 43, Pa.

For more details circle #956 on mailing card.
(Continued on page 186)



LIQUI-MED

... New Dimension in Therapy Regulators!

Streamlined, efficient function . . . that's the new dimension you get in Liqui-Med Therapy Regulators. Designed expressly for use by hospital personnel, they provide optimum accuracy, virtually eliminate mistakes.

Stainless steel diaphragm. Nylon pointed adjusting screw prevents metallic friction . . . exclusive REGULITE adjusting cap gives error-free settings . . . 4000 lb. H.P. CO₂ gauges for extra safety. Write for *free* literature.

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EXCLUSIVE! THE

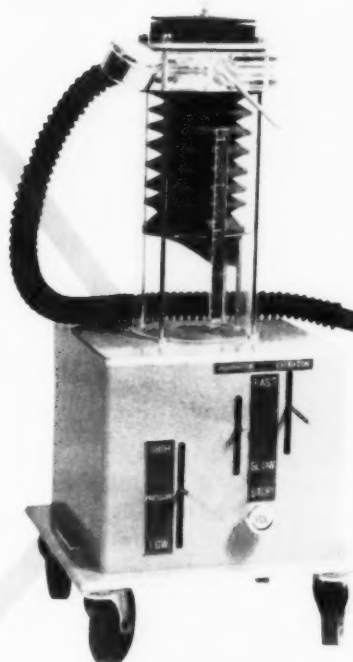
Mörch

SURGICAL RESPIRATOR

Designed by a doctor, one of America's leading authorities on anesthesia, the Mörch Respirator provides safe, efficient, up-to-date surgical techniques.

- Operated by compressed air or oxygen—no electrical components.
- Easy adjustment of rate, pressure and volume.
- Follows patient's normal respiration.
- Connects to any anesthesia apparatus, or can be used without apparatus.
- Reduces the amount of anesthesia needed.
- Silent operation provides a quieter surgical field.
- Relaxes the abdominal wall.
- All rubber parts are conductive.

Now exclusively represented by Liquid Carbonic.
Write for full particulars.



LIQUID CARBONIC

DIVISION OF GENERAL DYNAMICS CORPORATION
3100 South Kedzie Avenue, Chicago 23, Illinois

WHAT'S NEW



**Quiet Operation
for Lightweight Vacuum**
The new Kent Quiet Junior Vacuum

weighs only 34 pounds and with the tricycle-type rolling gear and convenient tubular handle is easy to manage, either on the level or going up and down stairs. It provides the suction, air velocity and performance of larger machines, according to the manufacturer, yet is quiet, readily mobile and easy and economical to operate. The machine is equipped with disposable paper filter bags and has a fully adjustable water shut-off. In addition to floors and rugs, the Kent Junior will clean mattresses, bed springs, venetian blinds, window sills, radiators and other areas. The Kent Co., 736 Canal St., Rome, N.Y.

For more details circle #957 on mailing card

20-Quart Mixer in Table Model

Designed especially to handle a variety of kitchen tasks, including mixing, beating or whipping of various types of foods, the new Toledo 20-Quart Mixer has an auxiliary power socket for accessories. It can thus be adapted for use in meat and food chopping, slicing, juice extraction and sharpening. The swivel mounted bowl saddle swings to the right for use with accessories mounted in the auxiliary power socket. The mixer



is finished in two shades of gray with heavily tinned bowl for complete sanitation. Toledo Scale Co., 1023 Telegraph Rd., Toledo 13, Ohio.

For more details circle #958 on mailing card

GRAND RAPIDS

Schwartz
SECTIONAL SYSTEM

BE SURE...

...you buy and receive

GENUINE

Schwartz **UNITS**



Units can be arranged to fit any pharmacy layout, any set of working conditions. Whether you plan to remodel or design a new pharmacy, our distributors will gladly help you in selecting appropriate units. Or if you wish assistance in establishing a complete plan, our Equipment Planning Department can furnish detailed layouts and specifications.

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Colorimetric Strip Text for Proteinuria

Albustix is a new colorimetric strip test for proteinuria. The strip is dipped in urine and compared to a color scale on the bottle label. The reagent strips employ the same chemical principles as Ames reagent tablets and both tests provide color guides as points of reference for interpreting results. Albustix Reagent Strips in bottles of 120 offer a simple, convenient method with no clean-up time required. Ames Company, Inc., Elkhart, Ind.

For more details circle #959 on mailing card.

Spray and Liquid Insecticides for Institutional Use

Two new insecticides have been developed for institutional use. Available in spray and liquid form, Johnson's Raid Bug Killer and Raid Insect Spray contain a higher concentration of synergized pyrethrins than the household counterpart. They are non-toxic and safe to use around human beings or pets and are said to kill flying and crawling insects which have built up resistance to other insecticides. The pressurized spray is packed in 16-ounce containers and the liquid for use in mechanical dispensers, is available in one, five, 30 and 55 gallon containers. S. C. Johnson & Son, Inc., Racine, Wis.

For more details circle #960 on mailing card.

(Continued on page 188)



This close-up of a 9" x 9" tile is typical of the beautiful, soft marbling found only in Kentile rubber tile.

the extraordinary resilience and long wear of KENTILE® rubber tile is your best answer!

Every hospital deserves the restful atmosphere and cushioned beauty of Kentile rubber tile in rooms, corridors, and wards alike. Patients appreciate its cheerful colors and smart designs. Doctors and nurses welcome the fact it helps reduce fatigue. And hospital attendants find Kentile rubber tile is so easy to keep clean. Its pre-polished sur-

face resists dirt and stains, and because it's so exceptionally tough, floors look like new even after years of hard wear. Yet Kentile rubber tile (KenRubber®) requires minimum maintenance and expense. For details, just get in touch with your Kentile flooring contractor. He's listed under FLOORS in your Classified Telephone Directory.

KENTILE FLOORS

BROOKLYN 15, N. Y.

AVAILABLE IN • RUBBER • CORK • VINYL ASBESTOS • SOLID VINYL • CUSHION-BACK VINYL • AND ASPHALT TILE ... OVER 150 DECORATOR COLORS

Keeps liquids **HOT** or **COLD**

GRAND NEW *Stanley* **PITCHER-SERVER**

Full Quart Capacity!

- For room and bedside drinking water
- For dining room serving of "second cups" (eliminating those trips back to the kitchen)
- For dining car table use
- For steamship staterooms



**Wall Bracket
For Extra Convenience**

Handsome chrome-plated wall bracket holds pitcher-server snugly and safely. Padded lining protects polished chrome finish.

ORDER FROM YOUR SUPPLIER
OR WRITE:

STANLEY INSULATING DIVISION

of Lander, Frary & Clark, New Britain, Conn.

**FULFILLING THE STRICTEST DEMANDS
...FOR OVER A CENTURY!**



The kitchen and cafeteria equipment of the recently erected Abraham Jacobi Hospital* was completely fabricated and installed by Straus-Duparquet.

Designed to conform with the standards of the National Sanitation Foundation, this all stainless steel equipment functions with the efficiency and economy afforded only by the most modern techniques of our day.

Our vast experience and facilities permit us to meet your most exacting standards. Contact our firm nearest you for further information.

*Abraham Jacobi Hospital, Bronx, N.Y., erected by the New York City Dept. of Public Works, Frederick H. Zornmühlen, P.E., R.A., Commissioner; Pomerance & Breines, Architects.



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WHAT'S NEW

**Professional Scale
Has Streamlined Design**

The Health-o-Meter 400 is a new model scale combining modern design with Continental Scale quality. Every detail is engineered for accurate and efficient service, while providing modern, streamlined appearance. The die-cast, chrome-plated beam is designed for easier reading and has a capacity of 350 pounds. The hardened, keen edged pivots are mounted on glass-hard steel bearings to eliminate wear.



All functional parts are completely enclosed while base, platform and levers are permanently factory-assembled to prevent disengaging at any time. New materials are used to produce the unusual finish. The two-piece, telescoping measuring rod of heavy steel tubing is black enameled with graduations and figures in white for quick, accurate reading. The scale, with or without the measuring rod, is available in a choice of white or four baked enamel colors. Continental Scale Corp., 5701 S. Claremont Ave., Chicago 36.

For more details circle #961 on mailing card.

**Improved Conductive Bootie
Provides Positive Contact**

Positive skin-to-floor contact is maintained by a snap-on elastic garter assembly



with contact plate in the improved Legge Conductive Bootie. Worn over ordinary shoes by surgeons, surgical nurses and others in the operating room, the new bootie is ankle height, cool and comfortable and easily laundered. It is not necessary to assign individual pairs and it can be worn by men or women. Relatively low in cost, the Legge Conductive Bootie is available in four sizes. Walter G. Legge Co., Inc., 101 Park Ave., New York 17.

For more details circle #962 on mailing card.

(Continued on page 189)

WHAT'S NEW

Steam Vaporizer Is Low in Cost

The Rochester Steam Vaporizer is a low-cost model providing a simple and efficient means of supplying warm, moistened air for treatment of respiratory disturbances. Steam is generated quickly in the water reservoir. It passes through a patented air injector which draws in a predetermined amount of cool air, pro-

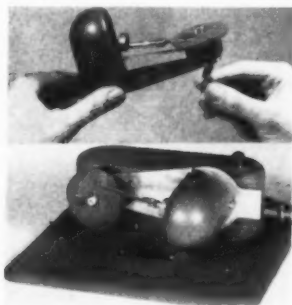


ducing a supersaturated vapor. The flexible tube permits projecting the vapor from the nozzle in the desired direction. The unit holds sufficient water for nine hours of operation on one filling, is constructed of stainless steel and is easily carried by the plastic handle. Rochester Products Co., 300 First St. N. E., Rochester, Minn.

For more details circle #963 on mailing card.

Hypo Sharpeners Hand Operated and Motorized

Nylon gears are used to give increased life to the two new models of Franz Hypo Sharpeners. Streamlined design,



mechanism enclosed for greater protection and quick and skillful sharpening are added features of the new models. The hand operated Model H-O-D and the motorized Model M-O-D both produce scientifically correct points and remove ordinary fish-hooks in seconds. They sharpen all gauge needles to two inches in length. The new motorized model has a base plate and a signal light indicates when the instrument is turned on. Franz Mfg. Co., Inc., 53 Wallace St., New Haven 11, Conn.

For more details circle #964 on mailing card.

Vinyl Tile Sealer Gives Excellent Wax Base

Flor-Life is a new vinyl tile sealer which dries to a tack-free, buffable finish in 15 to 20 minutes. It is a colorless, heavy-bodied, non-yellowing product which provides an excellent base for wax and will not darken even the lightest floors. Flor-Life improves the wearing qualities of wax and enhances the appearance of the final wax coat. It may be used on terrazzo and linoleum as well as on pure vinyl and vinyl asbestos tile. Multi-Clean Products, Inc., 2277 Ford Pkwy., St. Paul 1, Minn.

For more details circle #965 on mailing card.

Press-Down Nozzle Cleans Any Type Bottle

To speed up bottle washing, T & S has developed a new type of bottle washing nozzle for use on bottles or other containers of any size or shape. Thorough and quick cleaning is accomplished by nine powerful jet washing streams which are actuated by pressing the bottle down over the nozzle on a wide perforated disc. Water shuts off automatically when the vessel is withdrawn. T & S Brass & Bronze Works, Inc., 32 Urban Ave., Westbury, L.I., N.Y.

For more details circle #966 on mailing card.

(Continued on page 190)



Place a No. 1 Brillo Floor Pad under your floor machine . . .



Dry-clean your floor every day.



Use a side-to-side motion to remove dirt and harden finish.

AFTER your floors have been cleaned and waxed, you can easily maintain their original shine.

KEEP FLOOR SHINE LONGER

Fresh wax is a tough, transparent film which protects your floor from wear and enhances its beauty. Dirt, grease, foreign particles from traffic become imbedded and spoil floor appearance, as well as causing extra wear. A daily buffing with a No. 1 Brillo Solid Disc Steel Wool Floor Pad removes this dirt and hardens the wax, leaving a clean, gleaming floor, every time.

BRILLO MANUFACTURING COMPANY, INC.

60 JOHN STREET, BROOKLYN 1, NEW YORK

DRY-CLEAN YOUR FLOORS with BRILLO® FLOOR PADS

*... make your waxing
last twice as long*

YOU SAVE FOUR WAYS

Daily dry cleaning with Brillo Floor Pads makes your original waxing last twice as long. You benefit four ways because: 1. You preserve the floor itself . . . 2. You avoid frequent stripping of the finish and the necessity of rewaxing . . . 3. You save labor for scrubbing and mopping . . . 4. Your floors will have added beauty.

A PAD FOR EVERY JOB

Brillo Floor Pads are available for all makes of rotary electric floor machines from 8" to 21" diameters and in grades 0, 1, 2, 3 for any cleaning, waxing or buffing operation. Write for free informative booklet.

WHAT'S NEW

Disposable Oxygen Mask for Children

Made especially for children up to five years, the new Kiddie Space Mask is designed to allay the child's fear when oxygen therapy must be administered. The colorful masks depict a tiny spaceman standing beside his space jets. The K-S Disposable Oxygen Mask is also useful in induction of anesthesia in small children. The mask is lightweight and completely sanitary and is designed to be disposable. **Ohio Chemical & Surgical Equipment Co., Madison 10, Wis.**

For more details circle #967 on mailing card.

Soya Infant Formula in Powdered Form

Sobee Powder is a new form for the hypoallergenic soya infant formula designed for infants who are sensitive to cow's milk. It has the same hypoallergenic properties and caloric distribution as Sobee Liquid. Either product is used simply by mixing with water. The powdered product was developed because of its greater convenience to the user. It is supplied in one pound cans with special measure enclosed. **Mead Johnson & Co., Evansville, Ind.**

For more details circle #968 on mailing card.

Mop Truck Has Improved Design

A major wheel change and streamlined design are incorporated into the Finnell 56-gallon mop truck. The new wheel has a semi-pneumatic, eight-inch diameter tire and the $\frac{3}{8}$ inch axle bore is equipped with sealed ball bearings. Load rating has been increased. The streamlined design of the truck conserves storage space and the wheels, two



of which swivel, are recessed. The truck is ruggedly constructed of galvanized or stainless steel. **Finnell System, Inc., 1400 East St., Elkhart, Ind.**

For more details circle #969 on mailing card.

The Service is Excellent— with beautiful Boontonware

Note the many ways Boontonware enhances a reputation for good service — and makes that service easier to maintain! There are decorator-inspired colors to make a meal look more inviting. There are no unsightly chips or cracks... Boontonware is practically indestructible! In Boontonware, food stays hot or cold longer. Service is quieter; no clatter in handling. Clean-up is quicker; Boontonware stacks evenly, is easy to keep up to high standards of cleanliness.

This finest of Melamine dinnerware is found in millions of homes, in all fine hospitals, schools and restaurants. It behaves as good dinnerware should. It practically *pays for itself!*

For a complete line — plates, bowls, cups and service dishes — see your regular supply house or write us for the name of your nearest dealer.

SIX COLORS TO MIX OR MATCH
Butter Yellow - Honeydew Green - Bon Bon Pink
Powder Blue - Tawny Buff - Shell White

Boontonware®

FINEST OF ALL MELAMINE DINNERWARE



Boontonware complies with CS 173-50, the heavy-duty melamine dinnerware specifications as developed by the trade and issued by the U. S. Department of Commerce, and conforms with the simplified practice recommendations of the American Hospital Association.

MANUFACTURED BY BOONTON MOLDING CO., BOONTON, NEW JERSEY

Paint Washed Away with Remover

Paint, varnish and lacquer are easily removed from wood and metal surfaces by applying a new paint remover with an ordinary paint brush and directing a strong spray of water on the coated surface. Known as Rinse Away Paint and Varnish Remover, it allows paint to be washed away within 15 to 30 minutes after application, leaving bright, clean surfaces which need no other treatment before repainting. Rinse Away remover leaves no residue, is non-inflammable and may be used as a cleanser in reconditioning old bristle and nylon paint brushes. **Pittsburgh Plate Glass Co., 632 Ft. Duquesne Blvd., Pittsburgh 22, Pa.**

For more details circle #970 on mailing card.

Non-bearing Partition Minimizes Sound Transmission

The new Penn Metal partition system is designed to minimize sound transmission from room to room. Known as the Hush Clip System, the partition achieves a sound transmission rating loss of 56.4 decibels. The system is based on the new Hush Clip used in conjunction with a $\frac{1}{4}$ -inch pencil rod, and steel studs, track and gypsum plaster over metal lath. Sound transmission is reduced because direct wall-to-wall contact is made only at point of clip. The Hush Clip system does not require cork strips and is only $5\frac{1}{4}$ inches thick. **Penn Metal Co., 40 Central St., Boston 9, Mass.**

For more details circle #971 on mailing card.

(Continued on page 192)



How Mt. Sinai Hospital gains nursing time, cuts foot travel, speeds all services!



AUDIO-VISUAL NURSE CALL SYSTEM. At Mt. Sinai, Executone's two-way voice communication between patient and nurse cuts nurse's foot travel more than 60%...allows nurse more time for actual patient care.

New York's famed Mt. Sinai Hospital has pioneered in the application of electronic voice communication. Starting 14 years ago with its first Executone Intercom System in the Radiology Department, Mt. Sinai quickly extended the use of this modern time-saving equipment.

Today, Executone is an integral part of Mt. Sinai, serving the entire hospital. With 325 beds already served by Executone's Audio-Visual Nurse Call System, Mt. Sinai has applied other Executone intercom and sound systems to its many services and departments. Thousands of needless steps are saved daily at Mt. Sinai with Executone—clear, distinct two-way conversations take place at the touch of a button. The over-all result is more personalized patient care and improved administrative efficiency.

Hospitals throughout the nation have discovered the effectiveness, economy and complete dependability of Executone for *all* services. Executone's Audio-Visual Nurse Call System alone is now serving over 12,000 hospital beds. Find out—*without any obligation*—how Executone can work for you as it does for Mt. Sinai and the entire hospital field. Write to Dept. D-12 for further information: Executone, Inc., 415 Lexington Avenue, New York 17, N. Y. (In Canada—331 Bartlett Avenue, Toronto.)

Executone

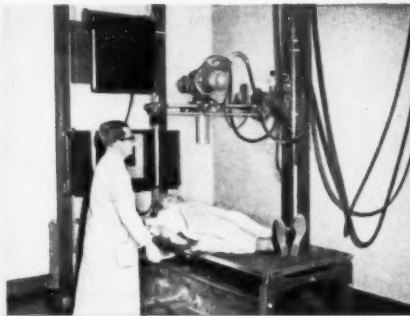
HOSPITAL COMMUNICATION SYSTEMS



NON-CORRIDOR PAGING. Doctors' paging calls at Mt. Sinai are reproduced at Nurses' Stations—not in Patient Corridors. (Arrow indicates paging unit.)



CENTRAL KITCHEN COORDINATION. An average of 6600 meals are served daily. Executone speeds activities with communication between Steward, Dietician, Food Preparation and Serving areas.



RADIOLOGY TRAFFIC CONTROL. Handling of patients coordinated through Executone between technicians, Reception area, Dark room, Film Files, and Chief Radiologist.

WHAT'S NEW

Junior Restraining Tray Facilities Care of Children



A larger edition of the Ivanhoe Restraining Tray is now available for use with children from one to four-and-a-half years

of age. The Junior Restraining Tray restrains the child safely and firmly without pressure. Anesthesia, surgery, intravenous therapy, x-rays and other procedures can be easily accomplished without extra personnel when the tray is used.

Made of heavy duty, specially compounded non-allergic Styron, the tray is molded for comfortable fit and precision screws permit accurate adjustment to the individual child. The tray is easily washed with soap and water or may be chemically sterilized if desired. It is easy to handle and fits on any operating table or stretcher. **Ivanhoe Enterprises, Inc., 111 Cathedral Ave., Hempstead, L.I., N.Y.**

For more details circle #972 on mailing card.

Stainless Steel Ice Cart in Two Sizes

The new Model 1001 Stainless Steel Ice and Shelf Cart is suitable for complete, partial, routine-refill or emergency use. It has a 50-pound capacity ice chest which can also be used for ice cream or bottled drinks. Space is provided in the cart for clean and used glasses, jugs, trays and straws.

Five-inch rubber tired wheels make the new cart easy to handle and rubber



bumpers protect against wall damage. Model 1001 is 41½ inches high, 34 inches long and 22 inches wide, with a working height of 35 inches. Also available is the new smaller Model 1002 with 25-pound ice capacity. **Gennett and Sons, Inc., One Main St., Richmond, Ind.**

For more details circle #973 on mailing card.

MISS PHOEBE

NO. 20 IN A SERIES



"All I said was, 'So your E&J chair folds to ten inches—so what?'"



You can be proud of your E&J chairs, too. Their easy fingertip folding is apparent at once. But even more important to economy-wise hospitals is the E&J feature that takes decades to discover: the chairs simply refuse to wear out.

Specify **EVEREST & JENNINGS** chairs
for your hospital

EVEREST & JENNINGS, INC., 1803 PONTIUS AVE., LOS ANGELES 25, CALIF.

Auxiliary Lighting Units Have UL Approval

Several new models are available in the Edison line of emergency, auxiliary lighting units. An automatic source of illumination during power failures, the new models have four and eight hours burning time and are designed for 115-volt, 60 cycle alternating current operation. A built-in rectifier keeps the battery charged either at a trickle rate during normal operation or at a high rate following emergency operation. The auxiliary units are said to meet the standards established by Underwriters Laboratories and a majority of local safety codes. **Thomas A. Edison Industries, West Orange, N.J.**

For more details circle #974 on mailing card.

Pudding and Pie Fillings in Five Flavors

A new Lemon Flavor and a new Coconut Flavor, added to Universal's line of pudding and pie fillings, brings the available flavors to five. Other flavors now in the line include chocolate, vanilla and butterscotch. Specifically developed for institutional feeding, the fillings result in maximum yield per ounce of pudding powder with lower cost per service to the institution and saving in time due to their quick preparation. **Universal Food Corp., 3005 W. Carroll Ave., Chicago 12, Ill.**

For more details circle #975 on mailing card.

(Continued on page 193)

WHAT'S NEW

Patient Statistics Simplified With Data Processing Machine

The Keysort Tabulating Punch is an automatic data processing machine intro-



ducing a new idea in automation for low-cost Keysort punched card procedures. The new adding, printing punch automatically punches and tabulates quantities and amounts in Keysort cards. It has varied applications, including requisition charge tickets and patient statistics in the hospital. The new machine can be integrated into existing Keysort systems with minor changes in present procedures.

The new machine is as simple to operate as a standard ten-key adding machine, yet it performs a multitude of operations. Data is entered from the simple keyboard and is instantaneously code-punched in the body of the Keysort card and accumulated in the machine. All amounts print on the adding machine tape. Grooves punched along the edge of the card are unaffected.

The same machine senses quantities or amounts and automatically adds, non-adds or subtracts, as required, printing the results on the tape. Indicators permit selective operations. The machine is relatively small and compact and operation can be quickly learned. Royal McBee Corporation, Westchester Ave., Port Chester, N.Y.

For more details circle #976 on mailing card.

Nimble Fingers Gloves of Tissue-Thin Pylox

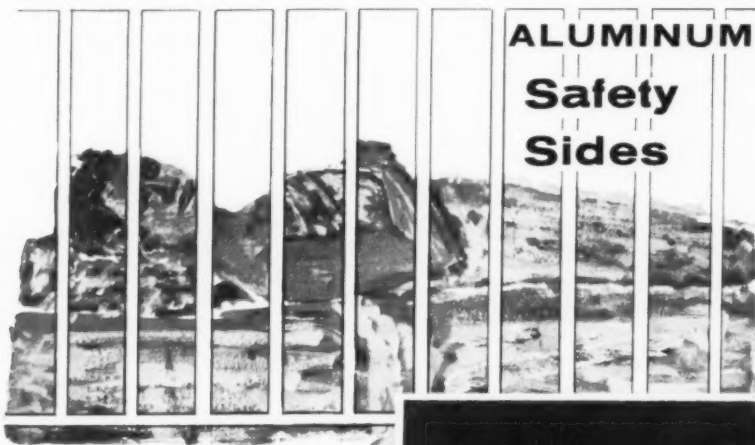
Tissue-thin Pylox is used to form the new Pioneer Nimble Fingers gloves. Designed for use on jobs requiring no lessening of finger sensitivity and dexterity, the new gloves are so sheer a single hair can be felt through them. They are textured inside to slip on quickly without talcum and can be reversed to give a non-slip grip on the outside when required. The gloves are a translucent lemon color, are thinner than sheer surgical gloves, and are resistant



to normal acids, alkalis, oils and greases. Nimble Fingers Gloves are available in small, medium and large sizes with curved, fitted fingers. The Pioneer Rubber Co., Willard, Ohio.

For more details circle #977 on mailing card.

(Continued on page 194)

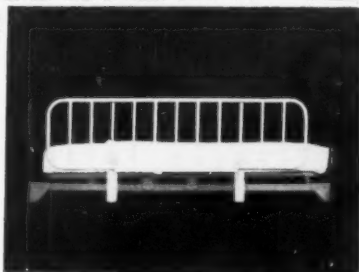


ALUMINUM Safety Sides

Safe

Positive

Ease of attachment, operation, removal. Nylon bearings, single knob clamping. Aircraft alloys for high strength, anodized for easy maintenance.



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MORE THAN EVER, the Beck-Lee *Cardi-all* is truly a superior EKG instrument. New, exclusive Lifetime-Guaranteed Standardization Cell and Solid Mahogany Cabinet add prestige and lasting accuracy to its already famous features:

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- all dealer

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Address.....
City.....Zone.....State.....

WHAT'S NEW

Molded Plastic Bedpan Is Bacteriostatic

Molded of white plastic by the new Corobex process, the Germfighter bedpan



is bacteriostatic and fungistatic. The plastic material is also non-toxic and non-allergenic. Virtually unbreakable, the Germfighter bedpan cannot dent, chip, peel or

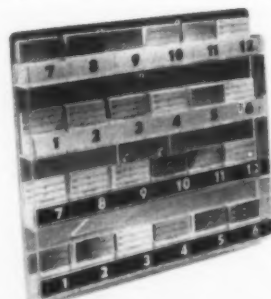
corrode and has natural warmth and flexibility for patient comfort. It also is quiet in use. Zylon Products Co., Inc., 27 Dryden Lane, Providence 4, R.I.

For more details circle #978 on mailing card.

Medicine Card Holder Employs Black and White

Dark numerals on white background for the morning shift and white numerals on dark background for the evening hours are used in the new Tomac Medicine Card Holder. Cards are kept perfectly organized in the holder with savings in time and lessened possibility of error. Cards are advanced forward into the next hour com-

partment as indicated by the doctor's orders, after rounds are completed. The holder is formed of sturdy, clear Plexiglas with pre-drilled holes for hanging on the



wall and an easel-type backrest for use on desk or table. American Hospital Supply Corp., Evanston, Ill.

For more details circle #979 on mailing card.



*Something New
from Kalamazoo!*

*Don't —
Don't forget to mention
that it keeps non-conductive
plaster dust off the floor.*

the **Stryker** **PLASTERVAC**

Another new Orthopedic Frame development — the Stryker PlasterVac. This heavy duty vacuum combines with the Stryker Cast Cutter to eliminate messy plaster dust and cut clean-up time in half... a necessity in every plaster room!

The PlasterVac is stable and it can be rolled easily. It is available as a complete unit or can be readily adapted to your present cutter by adding a mounting post and shortening the cutter electrical cord. It is easy to convert it yourself but if you prefer send it to us with your PlasterVac order.

In either case — order now!



SURGICAL AND HOSPITAL EQUIPMENT

Orthopedic Frame Company

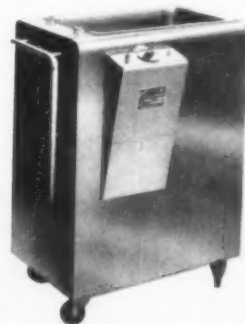
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Distributed in Canada by: Fisher & Burpe, Ltd., Winnipeg Exclusive Agent for Export: Schueler & Co., 75 Cliff St., N. Y.

Ultrasonic Washer Is Portable Unit

The Bunn-Glennite Ultrasonic Washer has a cleaning tank large enough to accept large instruments, pipettes and other items, yet is completely mobile. Mounted on conductive casters, the washer has drain and inlet hoses for a sink attachment similar to those on a household washing machine.

When the washer is installed, it is rolled to the sink, plugged into a three-wire receptacle and connected to the cold water tap. Operation is simplified and cavitation

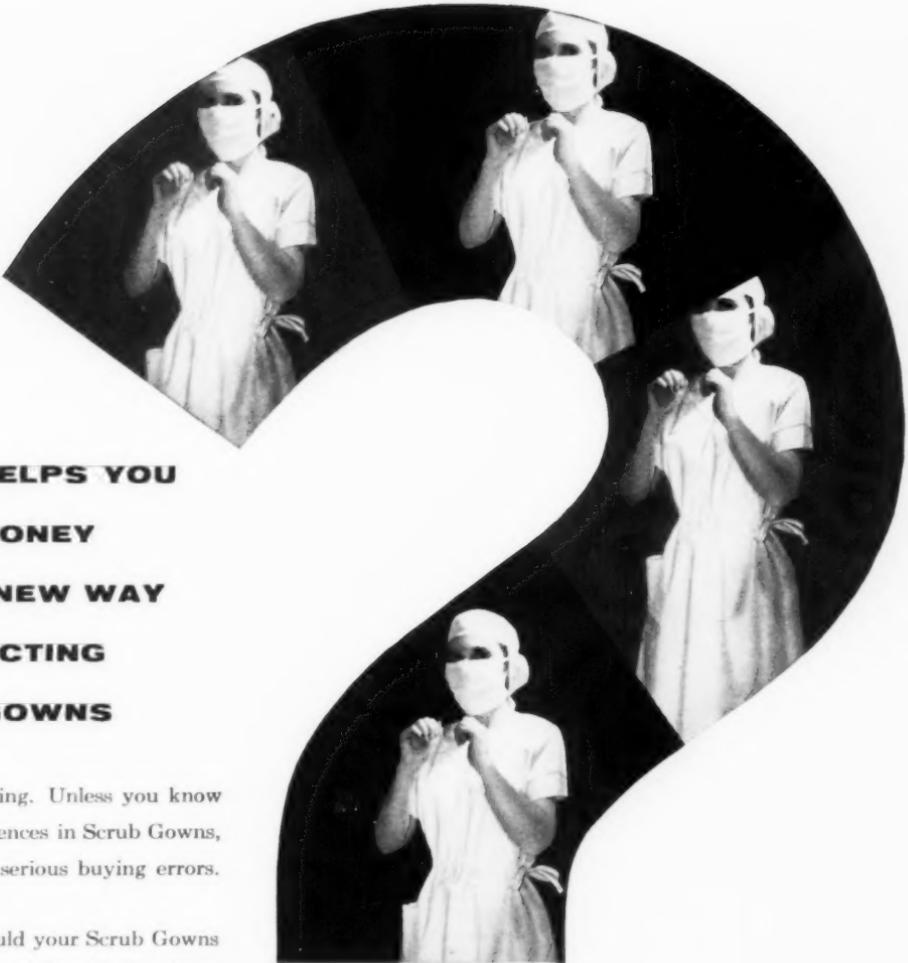


with its resulting cleaning action begins after a few minutes to warm up. With use of the proper non-sudsing detergent, instruments, syringes, needles and lab-ware are quickly and thoroughly cleaned with no scrubbing or handling. They are merely placed in the solution while the machine is turned on and all soil is completely removed, including the most stubborn materials.

The Model MU 1100 Ultrasonic Cleaner is housed in a stainless steel cabinet with waist-high grip handles for easy wheeling. The fixed-frequency, high-power generator is mounted inside on a rigid steel frame. The cabinet top contains a recessed 10-gallon stainless-steel tank, filled and drained by solenoid-operated switch buttons. The John Bunn Corporation, 163 Ashland Ave., Buffalo 22, N.Y.

For more details circle #980 on mailing card.

(Continued on page 196)



**ANGELICA HELPS YOU
SAVE MONEY
WITH THIS NEW WAY
OF SELECTING
SCRUB GOWNS**

Appearances are deceiving. Unless you know the important differences in Scrub Gowns, it is possible to make serious buying errors.

For instance, should your Scrub Gowns be slipover or back-opening? Should they have tunnel belts or detached belts? What is the most suitable color for your needs . . . misty green, jade green, grey, blue or white? "Plus" features may not always be obvious, but they are important to the durability and comfort qualities of the garment.

Every day more and more hospitals consult their Angelica Representative. His varied experience with hundreds of hospitals enables him to help you select the Scrub Gowns and other types of uniforms best suited to your specific needs.



Angelica[®]

UNIFORM COMPANY

1427 Olive, St. Louis 3 • 107 W. 48th, New York 36
177 N. Michigan, Chicago 1 • 110 W. 11th, Los Angeles 15

WHAT'S NEW

Blood Lancets Have "Sure-Grip Ridge"



Medipoint Blood Lancets have a new ridged design for easier and safer handling. The straight-line ridged stainless

steel adds strength and permits a quick, clean puncture without chance of slippage. Medipoint Lancets are individually wrapped, permanently sealed and sterilized, ready for use. Medipoint, Inc., 1155 Manhattan Ave., Brooklyn 22, N.Y.

For more details circle #981 on mailing card.

Dressing Cart Offered in Two Sizes

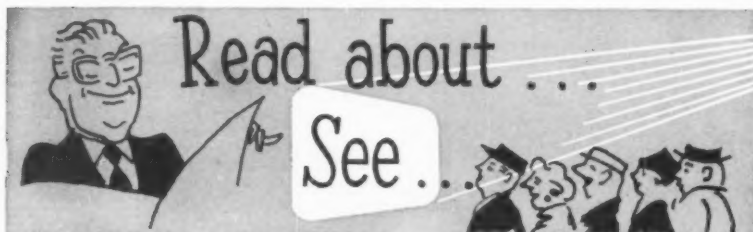
The Model D-1 Dressing Cart is available in two sizes. The D-1 is designed for use in larger hospitals and clinics while the D-2 is a smaller version for small hospitals, clinics and doctor's offices. All containers are of stainless steel

as is the bottom shelf, and equipment that is countersunk is standard. The two top shelves are of Plexiglass with



stainless steel used for the bottom shelf. The new cart is a complete, efficient unit. Samaritan Cart Co., York, Pa.

For more details circle #982 on mailing card.



NEW SPENCER Vacuslot

... the truly modern cleaning system

SEE for yourself why this easily installed, inexpensive, completely practical cleaning system is proving so popular. There's just nothing like it for schools, hospitals, other predominately bare floor buildings. VACUSLOT capitalizes on the ease and speed of dry mopping, yet assures the dust-free, germ-free sanitation that only vacuum can provide.

The SPENCER VACUSLOT System simplifies all cleaning tasks, including.

- Routine Maintenance • Vacuum Cleaning • Mop Cleaning
- Wet Pick-Up • Boiler Cleaning



NEW bulletin describes VACUSLOT System... contains "in use" photos, schematic drawings, sizing information and typical specifications. Request Bulletin 153C.

NEW 20 minute color movie shows typical Spencer Vacuum Systems in operation. Write requesting showing at your convenience.



The **SPENCER**
TURBINE COMPANY
HARTFORD 6, CONNECTICUT

Anesthetic Kit Is Readily Portable

The Epstein, MacIntosh—Oxford Anesthetic Outfit is a lightweight kit which is readily portable. Developed in England, it is being distributed in the United States by O. E. M. Corporation. The principal elements of the kit are the E. M. O. Inhaler and the Oxford Inflating Bellows. One simple knob controls the Inhaler which delivers any desired concentration of ether vapor, regardless of temperature variations. It is independent of gas cylinders and can be used with nitrous oxide and oxygen in the plenum system if desired. All necessary accessories are included in the kit which carries full instructions in the lid of the case. O. E. M. Corporation, East Norwalk, Conn.

For more details circle #983 on mailing card.

Tray Diet Cards in Fourteen Colors

Diet identification is speeded and errors reduced with use of the new Tray-Cards recently introduced. No holders are required for the colorful cards which



use bright, individual colors to identify 14 different hospital diets. The three-inch square front gives ample space for writing in patient's name, room, beverage preference and remarks. Meal-time prayers appropriate for Protestant, Catholic and Jewish patients are printed on the back. The new tray-cards come packed one diet classification to a box of 500. Colonial Hospital Supply Co., 5645 N. Ashland Ave., Chicago 26.

For more details circle #984 on mailing card.

(Continued on page 198)

Choose **NATCO**
for an always new look

Natco Ceramic Glaze Vitritile makes cleanliness easy in modern kitchens at the Grey Nuns Provincial House in Lexington, Mass.

Architect and Engineer: Maguola and Quick, Baltimore, Md. General Contractor: N. S. Kelliher, Boston, Mass.

Permanent, Attractive, Maintenance-free **NATCO Ceramic Glaze Vitritile is ideal for modern school kitchens**

Natco Ceramic Glaze Vitritile makes possible a new concept of cheerful, colorful school interiors.

Natco Vitritile is available in 21 standard colors to assure creation of the exact color scheme and atmosphere desired. From the new speckled glaze through plain and mottled finishes every Natco shade is functionally correct in degree of hue and brightness.

But color is only one Natco Vitritile advantage. Economy—in initial cost and in maintenance cost are two other major reasons builders select Natco Ceramic Glaze Vitritile. It's an ideal material for use in schools and other institutional structures.

Where cleanliness and low upkeep are important considerations Natco Vitritile has great practical advantages. An occasional wash with soap and water is all that's needed to keep it spotlessly clean. In addition Natco Vitritile walls resist abuse . . . never require refinishing or redecorating.

Natco Vitritile helps cut original construction costs because strong

structural, fireproof walls and partitions with an attractive interior finish can be built in one operation . . . at one cost.

If you are responsible for institutional construction, modernization or maintenance whether it be corridors, cafeterias, offices, operating rooms, work areas, or wash rooms, you'll find Natco Ceramic Glaze Vitritile meets all design and construction requirements. Write for General Catalog S-57 for complete data on Natco Ceramic Glaze Vitritile and other Natco structural clay products.

SIZES AND SHAPES

Series	Nominal Face Size	Tile Face Size	Nominal Thickness
"8W"	8" x 16"	7 $\frac{3}{4}$ " x 15 $\frac{3}{4}$ "	2", 4"
"6T"	5 $\frac{1}{2}$ " x 12"	5 $\frac{1}{8}$ " x 11 $\frac{3}{4}$ "	2", 4", 6", 8"
"4D"	5 $\frac{1}{2}$ " x 8"	5 $\frac{1}{8}$ " x 7 $\frac{3}{4}$ "	2", 4", 6", 8"

NATCO

NATCO CORPORATION—GENERAL OFFICES: 327 FIFTH AVENUE, PITTSBURGH 22, PA., TELEPHONE GRANT 1-9370



SALES OFFICES
Boston 16, Mass., 20 Providence Street, Tel. Hubbard 2-3549—2-3556
Chicago 6, Ill., 205 West Wacker Drive, Tel. Franklin 2-5754
Detroit 2, Mich., 2842 West Grand Boulevard, Tel. Trinity 3-0310
New York 17, N.Y., 205-217 East 42nd Street, Tel. Murray Hill 4-1922
North Birmingham 7, Ala., P.O. Box 5476, Tel. Birmingham 4-1881
Philadelphia 2, Pa., 1518 Walnut Street, Tel. Pennypacker 5-5112

Pittsburgh 22, Pa. 327 Fifth Avenue, Tel. Grant 1-9370
Syracuse 3, N.Y., 1045 James Street, Tel. Syracuse 9-8222
CLAY PIPE SALES DIVISION
P.O. Box 207, Brazil, Indiana, Tel. Brazil 2347

IN CANADA
Natco Clay Products Limited, 57 Bloor Street West, Toronto 5, Ont.



WHAT'S NEW

Nylon Base Glides for Faultless Casters

High gloss finish is used on the new Nylon Base Glides introduced by Faultless. They move easily over floors and floor coverings without scratch, squeak or rust. In areas where climate or room conditions cause metal finishes to corrode, the nylon glides protect floor coverings. The glides have a tilting stem with 40 degree range of movement to assure flat set on floor. The new nylon glides are available with a variety of stems and sockets for application on wood or metal furniture and equipment. **Faultless Caster Corp., 1521 N. Garvin, Evansville 7, Ind.**

For more details circle #985 on mailing card.

Ten Products in Quaker Institutional Foods

The Quaker Oats Company is marketing a complete line of institutional products under the "Big Q" trademark. Consisting of ten new products, five cereals and five mixes, the new line is packed in distinctive blue carton packages with sealed inner liners. The products are specially formulated and packaged for quantity food preparation and include Aunt Jemima Portion Packed Pancakes and Quick Quaker Oats. The mixes not only save time in preparation but permit precise cost and quality control. **The Quaker Oats Co., Merchandise Mart, Chicago 54.**

For more details circle #986 on mailing card.

Liquid Surgical Dressing Tinted for Visibility

Aeroplast Liquid Surgical Dressing is now available tinted yellow for ready visibility. The original colorless dressing was frequently wasted by applying too much because it was not readily seen after application. With the new tinted product a light film can be sprayed to form a transparent protective dressing over any body surface, regardless of contour. The light film makes a strong and flexible dressing which withstands washing, friction and motion without restricting respiration, circulation or movement. It is non-toxic, non-sensitizing and non-allergenic and the transparency permits critical evaluation of healing progress without disturbing or removing the dressing. Aeroplast dressing is simply peeled off when no longer needed. **Aeroplast Corporation, 420 Dellrose Ave., Dayton 3, Ohio.**

For more details circle #987 on mailing card.

County Newspaper Praises Professional Fund-Raising Counsel

Ingham County News editorial sums up Ketchum, Inc. service

Excerpts from the *Ingham County News* Editorial Page, June 20, 1957:

"Before the campaign was launched the hospital board spent much time considering professional counsel. It was finally decided that in the light of 2 previous attempts at fund-raising for hospitals, professional advice and direction were needed. Ketchum, Inc., of Pittsburgh was engaged.

"After sizing up the situation, Ketchum, Inc., sent three of its best men to Mason. They studied community resources. They matched them with hospital needs. They built up categories of prospects. They enlisted men and women volunteers. They trained canvassers. They prepared educational material to sell the hospital idea. They worked hard. They gave advice which proved invaluable. They kept the organization clicking. They were instrumental in helping this community achieve



MASON HOSPITAL MASON, MICHIGAN

Goal: \$500,000
Raised: \$533,430

success in an undertaking that three months ago was called unrealistic. They helped local people to help themselves . . .

"This community needed professional help in its hospital campaign. What was paid Ketchum, Inc., for that professional help should prove to be the soundest investment this community has ever made."



KETCHUM, INC.

Campaign Direction • Public Relations

CHAMBER OF COMMERCE BUILDING
PITTSBURGH 19, PA.

500 FIFTH AVENUE, NEW YORK 36, NEW YORK
JOHNSTON BUILDING, CHARLOTTE 2, NORTH CAROLINA

Ketchup and Mustard in Individual Packets



Packet Brand UnitPackets of ketchup, mustard and grated Parmesan cheese offer economy and sanitation in the serving of these condiments. Time and labor are saved when the air-tight moisture-proof packets with easy-pour spouts are used in making up patient trays, at the end of the cafeteria line or on tables in visitor or personnel lunchrooms. Use of the UnitPackets permits accurate portion control. They can also be used where hot food is offered in off-hours through vending machines. **Unit-Packet Corp., Dept. T., Wilmington, Mass.**

For more details circle #988 on mailing card.

Re-Usable Sweatbands of Feather-Weight Cotton

The new expanded feather-weight cotton Sweatbands are described as re-usable at a disposable price. This sanitary safeguard for doctors and nurses keeps eyes and glasses clean. Its light weight makes it light, cool and comfortable. The light elastic band fits it comfortably to all head sizes. **General Bandages, Inc., 531 Plymouth Court, Chicago 5.**

For more details circle #989 on mailing card.

(Continued on page 200)



Patient care ... or paperwork ...

how does your dollar divide?



Often the promise of more and better *patient care* lies in the savings to be made on non-patient services. Today, how much of *your* precious budget dollar is needlessly being spent on a multitude of clerical services that *could* be handled automatically, economically — with IBM punched cards?

From patient billing to payroll, from medical records to materials control

... moving swiftly from task to task, flexible IBM equipment serves *every one* of your 15 basic accounting and record-keeping services.

As a result, you cut the price tag markedly on clerical and business services ... you develop less costly procedures ... increase accounting efficiency ... make *your* administration problems fewer and simpler.

Learn how a basic IBM installation

can help you apply more of your budget dollar to vital patient services. Just call your local IBM representative or write to: HOSPITAL DEPARTMENT A57, International Business Machines Corporation, 590 Madison Avenue, New York 22, N. Y.



WHAT'S NEW

Pharmaceuticals

Chymar

Chymar is a crystallized chymotrypsin in sesame oil with two percent aluminum monostearate, described as being particularly effective in combating serious bruises and hemorrhages in the tissues. Supplied in five cc. multiple dose vials for intramuscular injection, Chymar travels to places where inflammation exists and speeds the healing process. Clinical tests indicate that injection of the newly developed enzyme preparation speeds the healing of such widely different ailments as black eyes and varicose ulcers. **The Armour Laboratories, P.O. Box 511, Kankakee, Ill.**

For more details circle #990 on mailing card.

Biosynephrine Nasal Spray

Biosynephrine Nasal Spray is a new synergistic compound for the control of nasal or upper respiratory disorders resulting from multiple causes. The product is a nasal decongestant with antibacterial, anti-allergic and anti-inflammatory action. Through synergistic action the compound controls nasal or upper respiratory conditions due primarily to bacterial infection, but with allergic factors also present. It is also said to be effective against allergic conditions in which secondary bacterial infection occurs. The product is supplied in 15 cc. squeeze bottles. **Winthrop Laboratories, 1450 Broadway, New York 18.**

For more details circle #991 on mailing card.

Liquiprin

Liquiprin is a new analgesic-antipyretic in liquid form specially designed for pediatric use. It is described as being safer than aspirin and is supplied in a unique non-spill safety bottle. It is an especially stabilized suspension of salicylamide, chemically and pharmacologically distinct from aspirin and other salicylates. The new product relieves minor aches and pains while reducing fever and is said to be less toxic than aspirin, more rapidly absorbed with less gastric irritation. It is introduced as the result of research to provide a safe treatment to offset the adverse effects of aspirin on children recently reported. **Johnson & Johnson, New Brunswick, N.J.**

For more details circle #992 on mailing card.



DISH-WASHING DEPT.



CHRIST HOSPITAL

CINCINNATI

something old • something new in canny hospital improvement

- Not only are the workers more comfortable in the dish-washing department at Christ Hospital, Cincinnati, since the modernization . . . the director of dietetics and controller point with pride to the new high in sanitation and efficiency . . . the improvement cost will be wiped out in three and a half years by savings in labor and dish-washing compound.
- Although installed over 20 years ago, with a few modifications to fit the new model machines, the Van equipment is good for at least another 20 years or more, as the illustration depicts.
- Investigation might show you that replacements or modifications in your kitchen and service operations would improve efficiency, worker morale, and pay for themselves. Van would like to help you.

The John Van Range Co.
EQUIPMENT FOR THE PREPARATION AND SERVING OF FOOD

Branches in Principal Cities

401-407 EGGLESTON AVENUE

CINCINNATI 2, OHIO

Literature and Services

"The ABC's of Prenatal Care" is the title of a new 40-page booklet published by H. J. Heinz Co., for Heinz Baby Foods, Box 28, D-26, Pittsburgh 30, Pa. Designed to present the facts about parenthood in a reassuring way, the booklet was prepared by Heinz in cooperation with medical authorities, nutritionists and obstetrical specialists.

For more details circle #993 on mailing card.

A "Traction Test Kit" to demonstrate the unusually high traction of Matex surgeons' gloves on wet instruments or tissue is available from The Massillon Rubber Co., 121 Sixth St., N.W., Massillon, Ohio.

For more details circle #994 on mailing card.

"Prevent Needless Tragedy by Keeping Conductivity in Hospital Floors" is the title of an eight-page booklet prepared by the Hospital Division, Hillyard Chemical Co., St. Joseph, Mo. Employing no trade names or other advertising, the leaflet discusses hospital explosions, care and cleaning of conductive floors and concludes with a series of "Do's" and "Don'ts" for keeping conductive floors conductive.

For more details circle #995 on mailing card.

The complete line of recessed downlights, recessed domes, directional downlights, concentric rings, close-up and pendant domes, ceiling drums, wall brackets, glass spheres, single and multiple mounted swivels, specialized hospital lights and portable lamps is described in a comprehensive new catalog issued by The Kurt Versen Co., 4 W. Slocom Ave., Englewood, N.J. Completely indexed, the catalog includes information on construction features, installation data, optical data and lighting charts.

For more details circle #996 on mailing card.

Grant Cubicle Curtain Hardware is the subject of a new four-page catalog published by Grant Pulley and Hardware Corp. Describing the "newest, most highly engineered line of cubicle hardware for hospital cubicle curtain installations," the leaflet is illustrated with photographs and diagrams of the equipment as well as sketches of room installations. The company has recently moved from Flushing to a new, larger plant on High Street, West Nyack, N.Y.

For more details circle #997 on mailing card.

(Continued on page 202)



Who said dirt cheap?

Air-borne dirt is a costly enemy of health

Honeywell's Electronic Air Cleaner protects against this infection carrier 6 times better than mechanical filters.*

As you know, many air-borne bacteria, viruses and their carriers are less than 1/25,000 of an inch in size.

Now, microscopic particles this small—even 1000 times smaller—can be trapped by Honeywell's new Electronic Air Cleaner *before* they cause damage. Studies conducted by the U.S. Bacterial Warfare Center proved an electronic air filtration system can achieve a bacterial and viral arrestance of 90% or more.

This hygienic atmosphere helps safeguard both patients and personnel against acquiring infections

while they're *within* the hospital. The possibility of nosocomial infections can definitely be reduced in the nursery, surgery, delivery and patient rooms.

The kind of protection offered by a Honeywell Electronic Air Cleaner is impossible with an ordinary mechanical air filter. Only *electronically* can truly large amounts of unsanitary and unsightly dirt be removed. Cleaning and painting costs drop accordingly.

For details about installing a Honeywell Electronic Air Cleaner in your hospital, call your architect, engineer or local Honeywell office. Address your written inquiries to Minneapolis-Honeywell, Dept. MH-11-224, Minneapolis 8, Minnesota.

*According to tests developed at the National Bureau of Standards, electronic air cleaners remove at least 90% of the air-borne particles causing the greatest damage, while ordinary mechanical filters remove only about 15%.

Honeywell



First in Controls

WHAT'S NEW

• A new **Laboratory Glassware and Clinical Supplies Catalog** is now available from Glasco Products Co., 111 N. Canal St., Chicago 6. The 24-page guide describes and illustrates over 200 glassware items available to the hospital field.

For more details circle #998 on mailing card.

• A new **"Infinity Fabric" Brochure** has been released by Edwin Raphael Co., Inc., Holland, Mich. **Brochure No. 505** describes drapery and upholstery fabrics and illustrates 45 Infinity Print Designs. A color chart showing 24 colors accompanies the brochure.

For more details circle #999 on mailing card.

• Samples of the 22 colors in which Sanymetal Toilet Compartments, Shower Stalls and Hospital Cubicles are offered are shown in a new folder issued by Sanymetal Products Co., Inc., 1676 Urbana Rd., Cleveland 12, Ohio. Entitled "Sanymetal Palette of Colors," the folder provides a handy color guide for administrators, planning groups and architects.

For more details circle #1000 on mailing card.

• **"Graphic Design in Eternal Metals"** is the title of a 2-color brochure illustrating and describing the architectural products in bronze, aluminum, nickel-silver, brass and stainless steel made by A. J.

Bayer Company, 2300 E. Slauson Ave., Los Angeles 58, Calif. Products include letters, signs, plaques, tablets and other art metal symbols.

For more details circle #1001 on mailing card.

How the **Pagemaster Selective Radio-Paging System** locates key personnel instantly, individually and privately is discussed in a new four-page folder available from Stromberg-Carlson, Division of General Dynamics Corp., Rochester 3, N.Y. How the flexible system fits any organization and gives positive paging is explained and facts about the system and its construction are presented.

For more details circle #1002 on mailing card.

• Full information on copper-lined storage water heaters for any commercial installation is given in **Data File 16** released by The Patterson-Kelley Co., Inc., East Stroudsburg, Pa. Designed to be used as a file folder, the material includes diagrams of construction details and specifications, data on dimensions and capacities, installation suggestions and case histories of typical installations.

For more details circle #1003 on mailing card.

• An unusual booklet on Carthage Marble, entitled **"A Story About Man and His Search for Beauty,"** is available from Carthage Marble Corp., Box N612MH, Carthage, Mo. Photographs of the world's great art and architecture in marble, as well as present day examples of the varied use of this stone, are shown. The large-sized brochure offers a handsome presentation of the story of marble.

For more details circle #1004 on mailing card.

• **"What Is Clean Air?"** is the title of a four-page folder on Cambridge air filters. The efficiency of air filtration is discussed, as is the cost, maintenance problem, flexibility and how to select the right filter. The folder is available from Cambridge Filter Corp., 738 E. Erie Blvd., Syracuse 3, N.Y.

For more details circle #1005 on mailing card.

• Bulletin 66, **"The ABC of Fire Protection,"** is a 36-page illustrated booklet offered by the "Automatic" Sprinkler Corporation of America, P.O. Box 360, Youngstown 1, Ohio. In addition to descriptive information on the complete range of fire protection equipment manufactured by the company, there is an explanation of the insurance savings and other economic benefits resulting from fire protection.

For more details circle #1006 on mailing card.

• Designed to help lengthen the life of kitchen equipment, a new 16-page manual, **"Care That Counts,"** is offered by Gas Consumers Service, 230 Park Ave., New York 17. Simple instructions on cleaning and caring for commercial cooking equipment are presented with information on how to determine the basic hot water needs for individual kitchens.

For more details circle #1007 on mailing card.

(Continued on page 204)



Less Friction...Less Wear

BECAUSE THE CARRIER MOVES ON PLASTIC WHEELS, Arncu Cubicles provide longer service. There is no sliding or binding friction to interfere with smooth and easy operation.



Heavy Duty Track for Rugged Hospital Use



EXCLUSIVE ARNCU ALUMINUM TRACK MAY BE FLUSH OR SURFACE MOUNTED WITH EITHER PLASTER OR ACOUSTIC CEILING

Completely unobtrusive . . . ARNCU CUBICLES do not conflict with lighting or wall fixtures . . . completely eliminate interference with doors or windows. Their specially designed curtains provide adequate ventilation in addition to privacy.

Zinc die cast axle provides extra carrier strength — has head chain for flexibility and rust-proof curtain hook. Soundly constructed to withstand years of constant, rugged service.

NEW! Low Cost Rack sturdily made in non-peeling aluminite finish . . . this easy to install coat and hat rack, or storage shelf finds innumerable uses in hospitals. Write for literature.

A. R. NELSON CO., INC.

210 EAST 40th STREET

NEW YORK 16, N. Y.



Here's the Soap that's
TAILOR-MADE FOR HOSPITAL USE!
Made According To YOUR SPECIFICATIONS!



We asked hospitals—just like yours—what features you would suggest for the *perfect* toilet soap. You said you wanted a quality soap—a soap that would give abundant lather in all types of water. You also specified that it be mildly fragrant and—above all—a hard-milled soap that would last longer. And here it is—Colgate's BEAUTY WHITE! The soap made according to your specifications. Make your next order BEAUTY WHITE. Patients will appreciate it—you'll *save money!*

Packed unwrapped for your convenience. 1½ oz.—300 in case, 3 oz.—144 in case. Also available wrapped in ½-oz. size only—1,000 in case.

★ FINEST QUALITY SOAP ★ GIVES ABUNDANT LATHER IN ALL TYPES OF WATER ★ UTMOST IN ECONOMY
 ★ SAME BASE—SAME PLEASING FRAGRANCE—AS COLGATE'S FLOATING SOAP



And For Your Private Pavilion—Mild and Gentle Palmolive Soap in its famous green wrapper. Quick lathering, meets highest hospital standards for purity, mild and easy on the skin. Write for sizes and prices.

FREE! Latest Edition Handy Soap and Synthetic Detergent Buying Guide. Tells you the right product for every purpose. Ask your C.P. representative for a copy, or write to our Industrial Department.



Colgate-Palmolive Company

300 Park Ave., N. Y. 22, N. Y. • Atlanta 5, Ga. • Chicago 11, Ill.
 Kansas City 5, Kans. • Berkeley 10, Calif.



WHAT'S NEW

SHROUDPAC

THE COMPLETE PACKAGE FOR HANDLING THE DECEASED

SHROUDPAC, the time-saving procedure for easier, cleaner, faster handling of the deceased. Special hospital white, fully opaque plastic shroud sheet respectfully shields the body from view and prevents embarrassing soilage. Always ready for instant use, no searching, no improvising. SHROUDPAC stores compactly in a handy six-unit dispenser.

For further information and samples, contact your SHROUDPAC distributor. (See below).

SHROUDPAC CONTAINS these necessary items: PLASTIC SHROUD SHEET (Adult Size or Child Size) • CHIN STRAP • THREE UNIFORM IDENT. TAGS • TWO CELLULOSE PADS • FIVE TIES

Each SHROUDPAC comes in a polyethylene bag designed to hold the personal belongings of the deceased.



Patton Hall, Inc.

2265 W. ST. PAUL AVE. • CHICAGO 47, ILLINOIS

SHROUDPAC is available through: A. B. Aloe Co.; American Hospital Supply Corp.; E. F. Mahady Co.; Meinecke & Co., Inc.; Physicians and Hospitals Supply Co., Inc.; Will Ross, Inc.; In Canada: Ingram & Bell, Ltd.

Autoclip[®]

APPLIER • REMOVER • CLIPS



for rapid wound clip placement and removal

CLAY-ADAMS, INC.
NEW YORK 10

• How to increase the service life of surgeons' gloves through proper handling is the subject of a wall chart offered by the surgical sales department of B. F. Goodrich Industrial Products Co., 500 S. Main St., Akron 11, Ohio. Careful step-by-step instructions for glove care, prepared by experts in the field of surgical rubber products, are presented on a plastic laminated chart, punched for hanging on a wall.
For more details circle #1008 on mailing card.

• "Immediate Postoperative Care" is the title of a new 25-minute, full color medical film showing a wide variety of procedures, equipment, drugs and special skills required to provide high quality care to patients during the immediate postoperative period. Filmed at the New York Hospital Cornell Medical Center under the supervision of Frank Glenn, M.D., Surgeon in Chief, and Doctors John M. Beal and Joseph F. Artusio, Jr., the 16mm film is available from Squibb, 745 Fifth Ave., New York 22.
For more details circle #1009 on mailing card.

• Specializing in fine bronze, aluminum, nickel silver, stainless steel and wrought iron fabrication, Meierjohan-Wengler Company, 1102 W. 9th St., Cincinnati 3, Ohio, has published the new "TL" Folder illustrating and describing its products. Over 100 illustrations of tablets, sculptured plaques, honor rolls, memorials and architectural metal letters in various styles, custom-designed and fabricated, are shown in the folder.
For more details circle #1010 on mailing card.

• How natural color post cards can be used by hospitals and related medical institutions as part of a dignified and economical public relations program is discussed in a four-color circular available from Curt Teich & Co., Inc., 1733 W. Irving Park Rd., Chicago 13. The Curteichcolor circular illustrates a variety of ways in which post cards can be used to help sell the hospital to its community.
For more details circle #1011 on mailing card.

Suppliers' News

The Burdick Corporation, Milton, Wis., manufacturer of equipment for physical medicine, announces the opening of a new building housing offices and the engineering department. Constructed to take care of recent company growth and expansion, the building was opened as part of the corporation's observance of its 45th anniversary.

Stephens-Banks Associates, Inc., 116 Delaware St., Detroit 2, Mich., is the new name of the recently merged food facility engineering companies, J. E. Stephens Associates, Inc., and the O. Ernest Bangs Associates. The new organization is designed to provide complete planning, design and engineering for all types of food service.

NO HANDS NEEDED

with Applegate's Foot or Motor Marker



APPLEGATE INKS

Applegate indelible (silver base) ink is everlasting . . . heat permanizes your impression for the life of the cloth, contains no analine dye.

Use the APPLEGATE SYSTEM

The Applegate marker is the ONLY inexpensive marker that permits the operator to use both hands to hold the goods and mark them any place desired. Hand, foot or motor power.

Write for information and free sample impression slip.



HOW TO SELECT THE APPROPRIATE BRONZE PLAQUE

Consult International Bronze for dignified, permanent bronze plaques. Remember, there's no finer aid to fund raising . . .

FREE Illustrated brochure shows hundreds of original ideas for reasonably-priced, solid bronze plaques, nameplates, memorials, etc.

Write today to Dept. 55

INTERNATIONAL BRONZE TABLET CO., INC.
150 West 22nd St., New York 11, N. Y.

PRODUCT INFORMATION

Index to "What's New"

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Key

- 939 Hospital-Master
Minneapolis-Honeywell Regulator Co.
- 940 Touch-Master Standard Typewriter
Underwood Corp.
- 941 Disposable Softi-Syringe
Chicago Apparatus Co.
- 942 Touch-n-Go Foodveyor
S. Blickman, Inc.
- 943 Weighing Stretcher
Jarvis & Jarvis, Inc.
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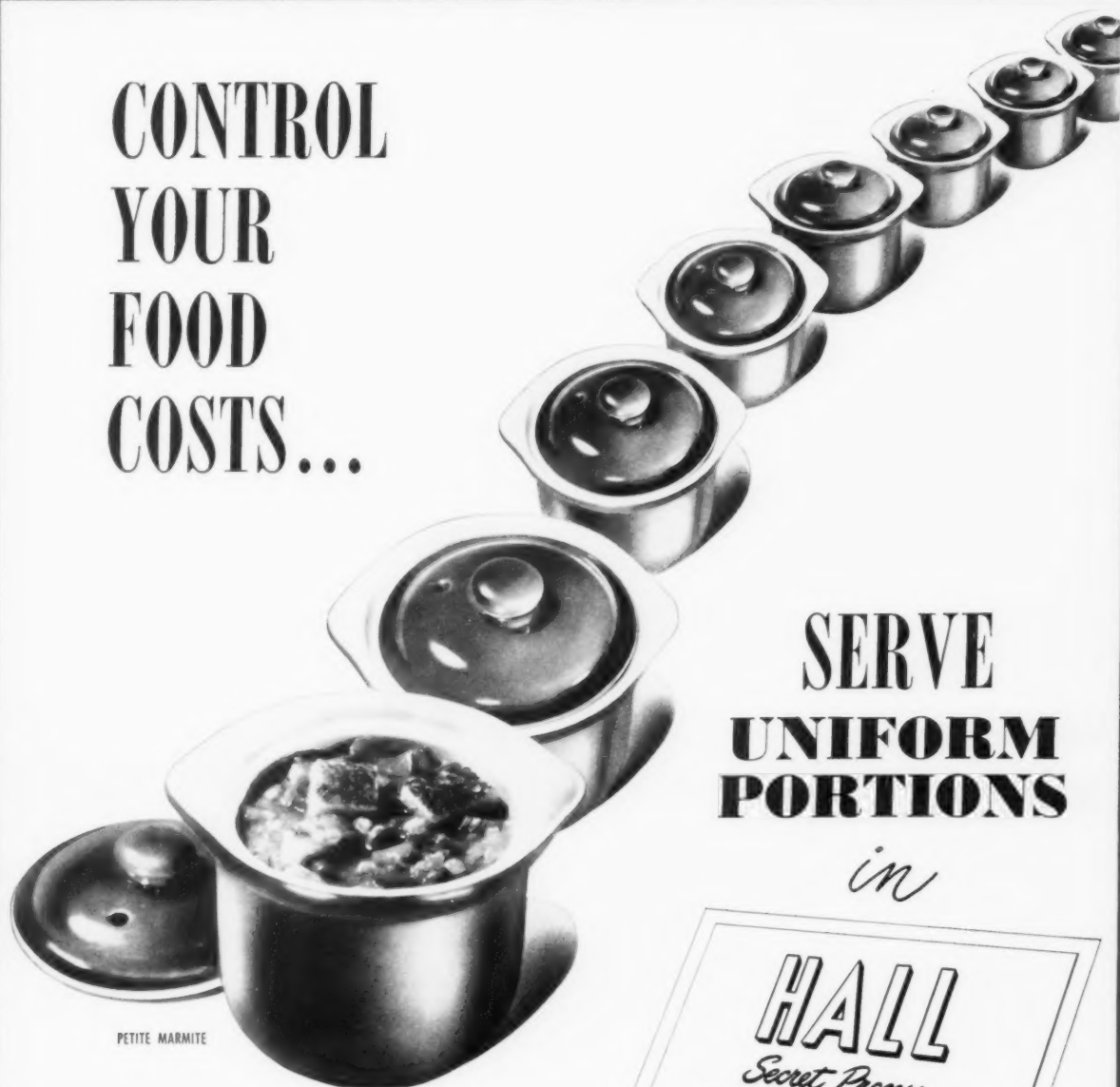
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